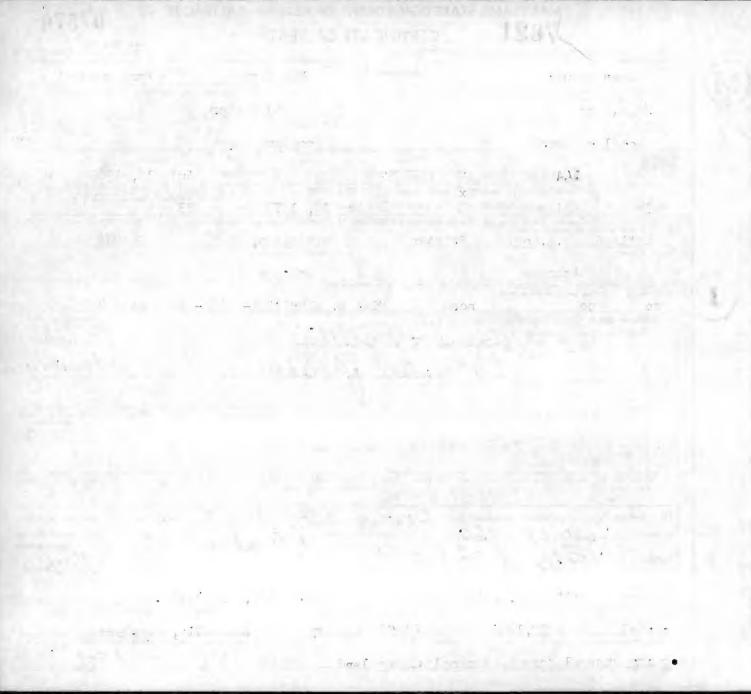
VS A15 (4) 15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7621

07570 CERTIFICATE OF DEATH Reg. Dist. No.

| 1. PLACE OF DEATH a. COUNTY Anne  | Arundel  |               | MARYLAND                 |         | JSUAL RESIDENCE                             | . 7                   | sed lived. If institut<br>b. COUNTY          | ian: Reside       | Aurn     | re odmis | ion)               |
|---|--|---------------|--------------------------|---------|---|-----------------------|--|-------------------|----------|----------|--------------------|
| b. CITY OR TOWN (III RURAL ond give no Edgewat  |  | ls, write     | c, LENGTH OF STAY IN 16  |         | 7.0   | outside con           | porote limits, write                         |                   |          |          | n)                 |
| d. NAME OF HOSPITA  | AL (If not in hospital, g                                    | ive street    | address)                 | 1       | d. STREET ADDRESS                           |                       | ch   |                   |          |          | FARM?              |
| 3. NAME OF<br>DECEASED<br>(Type or print)   | Fir  |               | Middle JAMIN ALBRITTO    | N       | Lost  | 4. DATE<br>OF<br>DEAT | Mo   | -                 | Do       |          | Yeor               |
| 5. SEX<br>Male  | 6. COLOR OR RACE White                                       | T             | TEDE NEVER MARRIED       | B. DA   | v 19. 187                                   | 777                   | 9. AGE (In years<br>lost birthday)<br>83 yrs | IF UNDE<br>Months | RIYEAR   |          | ER 24 HRS.<br>Min. |
| 10g. USUAL OCCUPATIO  | N (Give kind of working life, even if retired                | done 10b.     | KIND OF BUSINESS OR INDU | STRY    | N   | ote or foreign        | country)                                     | 12. CI            | TIZEN OF | WHAT (   | COUNTRY?           |
| TO THE DESCRIPTION  | Unknown  | erco la       |                          | 101500  | Unkno                                       | wn                    |  |                   |          |          |                    |
| 15. WAS DECEASED EVER<br>(Yes. no. or unknown) (  | R IN U. S. AKMED FOR<br>If yes, give war or dates of a<br>NO |               |                          |         | MANT<br>B. Albrit                           | ton- w                | ife- same                                    | iress<br>as #     | 7 2      |          |                    |
| Conditions, if are gave rise to in cause (a), stating I lying couse lost.  PART II. OTH | the <u>under-</u> DUE TO                                     | (             | CONTRIBUTING TO DEATH BU | O NOT   | Paladd                                      | RMINAL DISE.          | ase condition gi                             | VEN IN PA         | 0.1 E    | PERFC    | PRMED?             |
| (IF EITHER, NOTIFY  | CAUSE OF DEATH<br>MEDICAL EXAMINER)                          | 20b. DESC     | CRIBE HOW INJURY OCCURRI | ED. (En | iter nature of injury                       | in Part I or P        | ort II of item 18.)                          |                   |          | YES [    | NOX                |
| ZOC. TIME OF INJURY<br>Hour o. m.<br>p. m.  | Month, Doy, Ye   | While         |                          |         | OF INJURY (Hame, f<br>street, office bldg., |                       | lity or town)                                |                   | (County) |          | (Stote)            |
| actual SIGNATURE  | at I attended the willy 17                                   | deceas<br>196 | ed from Nov.             | M.D.    | , 19_57, ta_                                |                       | m the causes a<br>(Street, city or lown      | nd an th          |          | state    |                    |
| PHYSICIAN'S<br>NAME (Type)  | Willard F  | 2             |                          |         |   |                       | laryland                                     |                   |          |          |                    |
| 220. BURIAL, CREMATION<br>REMOVAL (Specify)<br>Burial                                   | July 20, 1   | 960           | Cedar Bluff              | _       | e ery                                       | Ann                   | CATION (City, town,                          | arvle             | nd       | (Sto     | 'e)                |
| 23. FUNERAL DIRECTOR'S Hopping Fur  |  | A             | ADDRESS                  | lar     |   | JUL 21                |  | istrar's s        |          |          |                    |



# CERTIFICATE OF DEATH

07571

| L_            |  |   |              |                      |            |        |   |   |   | Keg. Di   | \$1. No. |         |          |
|---------------|--|---|--------------|----------------------|------------|--------|---|---|---|-----------|----------|---------|----------|
| 1.            | PLACE OF DEATH o. COUNTY Anne Aru      | ndel  |              | M                    | ARYLAND    | 2. 1   | JSUAL RESIDENCE (Who<br>STATE<br>Maryland | ere decease                             | b. COUNTY                               |           |          |         | an)      |
|               |  | autside corporate lim                               | its, write   | c. LENGTH OF ST      |            |        | CITY OR TOWN (If a                        | utside carp                             |   |           |          |         | )        |
|               | Crownsvi                               |   |              | 7 mo y               | 28 day     | 8      | Baltimore                                 |   | 31                                      | SU.       | -7       |         |          |
|               | d. NAME OF HOSPIT<br>OR INSTITUTION    | AL (If not in haspital, )                           | ive street   | oddress)             |            |        | d. STREET ADDRESS                         |   |   |           |          |         | FARM?    |
| <u> </u>      | Crownsvi                               | lle State   | Hoapi        | tal                  |            |        | 1932 W. La                                | nvale                                   | Street                                  |           |          | YES [   | но 🚺     |
| 3.            | NAME OF<br>DECEASED<br>(Type or print) |   | <br>eorgi    | ***                  | idle       |        | lost<br>Au <b>try</b>                     | 4. DATE<br>OF<br>DEATH                  | Mont                                    | th        | Do 29    | '       | reor 60  |
| 5.            | SEX                                    | 6. COLOR OR RACE                                    |              |                      | PRISO III  | R OA   | TE OF BIRTH                               |   | 9. AGE th years                         | IF UNDER  |          | IF UNDE |          |
|               | Female                                 | Negro   | WIDOWI       |                      | RCED       |        |   | 1895                                    | last birthday)                          | Months    | Days     | Hours   | Min.     |
| 100           | . USUAL OCCUPATIO                      | IN (Give kind of work ing life, even if retired     | dane 10b.    | KIND OF BUSINES      | S OR INDU  |        | 11. BIRTHPLACE (State                     | or foreign (                            | country)                                | 12. CI    | IZEN O   | F WHAT  | COUNTRY  |
|               | Domestic                               | ing lire, even it refired                           | )            |                      |            |        | North Car                                 | olina                                   |   | U.        | S.A      |         |          |
| 13.           | FATHER'S NAME                          |   |              |                      |            | 14.    | MOTHER'S MAIDEN N                         |   |   |           |          |         |          |
|               | William                                | McSwain   |              |                      |            |        | Annie Bobb                                | ett                                     |   |           |          |         |          |
|               |  | E IN U. S. ARMED FOR                                |              | SOCIAL SECURITY      | NO. 17. I  | NFOR   | MANT                                      |   | Addr                                    | ess       |          |         | 1        |
| 111           | Unknown                                | If yes, give war or dates of                        |              | inknown              |            | Hos    | spital Reco                               | roie                                    | A. A. Co                                | ounty     | , Me     | 1.      |          |
| =             | 18. CAUSE OF DEA                       | TH [Enter only one ci                               | ouse per lie | ne for (o), (b), and | (c).]      | JAK WA | SULTERI HELLE                             | Lua                                     |   |           | INTE     | RVAL BE | WEEN     |
|               |  | TH WAS CAUSED BY:                                   |              |                      |            | Ha-    | ilure                                     |   |   |           | ONS      | ET AND  | DEATH    |
|               | 25                                     | IMMEDIATE CAUSE (                                   | 4            | -                    |            |        |   |   |   |           |          |         |          |
|               | 200                                    | DUE TO  | ,            | Use                  | perthy     |        | 4 A4 nm                                   |   |   |           |          |         |          |
|               | Canditions, if a                       | nmediate "  |              | щу                   | her on     | 110.   | LUISM                                     |   |   |           |          |         |          |
|               | cause (a), stating                     |   | )            |                      |            |        |   |   |   |           |          |         |          |
| ,             | lying couse last.                      | <b>y</b> (e   | )            |                      |            |        |   |   |   |           |          |         |          |
| CERTIFICATION |  |   | A.A.         |                      |            |        | RELATED TO THE TERMI                      |   |   |           |          | PERFO   | RMED?    |
| FIC           |  |   | Y            |                      |            | -      | ter noture of injury in P                 |   |   |           |          |         | 140 ==   |
| CERT          | OR CONTRIBUTING                        | S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER] | 200. 013     |                      |            |        | ner norozo or mjory m r                   | 0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , |           |          |         |          |
| SAL           | 20c. TIME OF INJUR                     | Y Manth, Day, Ye                                    | ar 20d. II   | NJURY OCCURRED       |            |        | F INJURY (Home, form,                     |   | y or lown)                              | (         | County   |         | (Stote)  |
| MEDICAL       | Hour o.m.                              | 19  | White of war | Not while            | fo         | ctory, | street, office bldg., etc.                | 1                                       |   |           |          |         |          |
| -             |  |   |              |                      |            |        | . 7                                       | /29                                     | 60                                      | -1 - 1    |          |         | decease  |
|               | 7/                                     | at I attended the<br>29                             | deceas       |                      |            |        |   |   |   |           |          |         |          |
|               | alive on                               |   | 18-          | and the              | hat death  | 000    | orred at 7 135A                           |   |   |           | he da    |         |          |
|               | ACTUAL                                 | Allama.   | 1.14         | 1                    |            |        |   |   | Street, city or tawn,                   |           |          |         | TE SIGNE |
|               | SIGNATURE                              | Filler  | 100          | 7                    |            | M.D.   | Crownsvil                                 | Le St                                   | ate Hospi                               | tal,      | Md.      | 7/2     | 9/60     |
|               | PHYSICIAN'S<br>NAME (Type)             | L. Benedi   | ct,          | 1. D.                |            |        | Crownsvil                                 | le St                                   | ate Hospi                               | tal,      | Md.      | 7/2     | 9/60     |
| 224           | BURIAL, CREMATIO                       | N, 225. DATE THEREG                                 | )f           | 22c. NAME OF C       | CEMETERY C | R CRE  | MATORY                                    | 22d. LOC/                               | TION (City, town, o                     | r county) |          | (State  | 1        |
|               | REMOVAL (Specify)                      | Aumati  | 1960         | Mt. A                | nburn      | Cer    | meterv                                    |   | Baltimore                               |           | ryla     |         |          |
| 23.           | FUNERAL DIRECTOR'                      |   |              | ADDRESS              | 7          | - 00   |   | BY REGIS                                |   |           |          |         |          |
|               | Deserous                               | mata.   | 0            | 911.6                | Omm.       | 2.1    | DATEAN                                    |   | 0 0                                     |           | 10       |         |          |

may ! Italianed by the haspital or attending physician.

TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death. TO MOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

ours after death. Page 4

VS A1S (4) 15M 9/5S

forth built from the business on his of the 2010 to the one of the term. when the state of the state of the state of . .

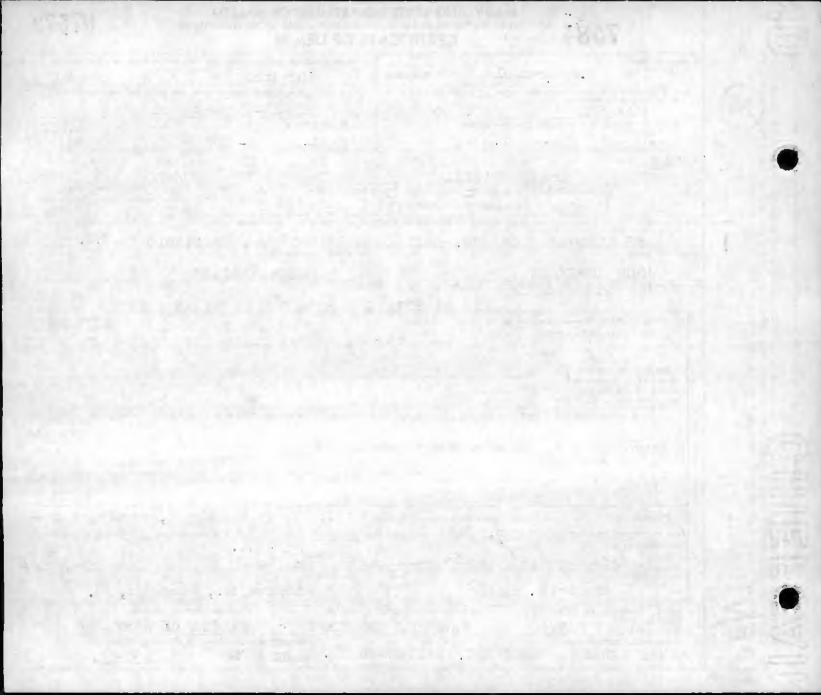
| 7584 | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MACCERTIFICATE OF DEATH |             |
|------|---|-------------|
|      | 2. USUAL RESIDENCE (Where deceased li   | ved. If ins |

| 1, PLACE OF DEATH   | A A 3 - 7   |                                | 2. USUAL RESIDENCE (W                                       |                        | lived, If institutio            | n: Residence I | before adm | issian)              |
|---|---|--------------------------------|---|------------------------|---------------------------------|----------------|------------|----------------------|
|   | Anne Arundel  | MARYLAND                       | Mary  |                        |                                 | Anne.          |            |                      |
| RURAL and give no   |   | c. LENGTH OF STAY IN 16        | c. CITY OR TOWN (IF   |                        |                                 |                | nearest to | ws)                  |
|   | polis   | 1 day                          |   | L - Ser                | verna Par                       | K              |            |                      |
| OR INSTITUTION  | TAL (If not in hospitot, give stree)<br>adel General Ho     |                                | d. STREET ADDRESS   | Box-                   | 167                             |                | ON         | A FARM?              |
| 3. NAME OF  |   |                                | 11 /2 3   |                        |                                 |                |            |                      |
| DECEASED<br>(Type or print)   | Harold C  | NEIL Middle                    | BERRYMAN  | 4. DATE<br>OF<br>DEATH | Jul                             |                | 6          | 19 60                |
| 5. SEX<br>Male  | White Widow   | RIED NEVER MARRIED DIVORCED DI | B. DATE OF BIRTH  |                        | 9. AGE (In years lost birthday) | Months Do      |            | - 1                  |
|   | ON (Give kind of work done 10b                              |                                | August 7, 18  |                        | 98 Atz                          | 12 (17)75)     | N OC WHAT  | COUNTRY              |
| during most of worl   | king life, even if retired)                                 |                                |   |                        |                                 |                |            | CODIVIKI             |
| 13. FATHER'S NAME   | MANAGER CAN   | CO. RETIREI                    | 8YRS Maryl  |                        | Baltimor                        | .6             | U.S.       |                      |
|   | DEDDIGUAN   |                                |   |                        |                                 |                |            |                      |
| JOHN 15. WAS DECEASED EVE   | BERRYMAN  | . SOCIAL SECURITY NO. 17. H    | EMM.  | A HAGO                 | FART Addr                       |                |            |                      |
| (Yes, na, or unknown)   | (If yes, give wat or doles of service)                      |                                |   |                        |                                 |                |            |                      |
| NO  | ATH [Enter only one cause per l                             | 215 09 6026                    | MRS ROSAMO  | ND BE                  | RRYMAN_S                        |                | IA PA      | RK                   |
| Conditions, if o<br>gove rise to i<br>cause (a), stating<br>lying cause last. | the under-  |                                |   |                        |                                 |                |            |                      |
| САТІС   | HER SIGNIFICANT CONDITIONS                                  | CONTRIBUTING TO DEATH BUT      | NOT RELATED TO THE TERM                                     | MINAL DISEASI          | E CONDITION GIV                 | en in part 1(  | PERF       | S AUTOPSY<br>FORMED? |
| OR CONTRIBUTING   | AS UNDERLYING (1) 20b. DE: CAUSE OF DEATH MEDICAL EXAMINER) | SCRIBE HOW INJURY OCCURRE      | D. (Enter nature of injury in                               | Port I or Part         | H of item 18.)                  |                |            |                      |
| 20c, TIME OF INJUR<br>Hour o. m.<br>p. m.                                     | While   | f -                            | ACE OF INJURY (Hame, for<br>ctory, street, office bldg., et | rm, 20f. (City         | or town)                        | (Cou           | nty)       | (Stote               |
|   | at (I) (this haspital) atten                                |                                |   |                        |                                 |                |            |                      |
|   | sed alive an July 6   | and that                       |   |                        | the causes and                  | d on the d     |            |                      |
| 220. SIGNATURE  | clant of  | lulu                           | ATTENDING A   | 5 P.M.  MED.  DIRECTOR | STAFF<br>PHYS.                  |                | 7-         | SIGNED               |
| 22c. PHYSICIAN'S<br>NAME (Type)   | Richard N. PEE  | LER                            | 22d. ADDRESS<br>121 Cathe                                   | dral S                 | t., Annap                       | olis,          | Md.        |                      |
| 23a. BURIAL, CREMATIC<br>REMOVAL (Specify)<br>BURIAL                          | 7/9/60  | PARKWOOD                       | OR CREMATORY CEMETERY                                       |                        | ION (City, town, o              |                |            | tate)                |
| 24. FUNERAL DIRECTOR  |   | ADDRESS<br>INC. BALTIMO        | 25o. REC  | D BY REGIST            | RAR 25b. REGIS                  | TRAR'S SIGNA   | ATURE      |                      |

TO HOSP-ALOR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 must after death. Page 4 may be may be made by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 shauld-be filed with the State Board of Health priar to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59



### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL

CE

|   | KESEMKCH | WIAD | KECOKD | 3   | DWLIMOKE | I, MARTLAND |  |
|---|----------|------|--------|-----|----------|-------------|--|
| Ī | RTIFICA  | ATE  | OF I   | DEA | HTA      |             |  |

07573

| PLACE OF DEATH  | ne arus   | del MARYLI                 | o STATE   | ENCE (Where despited                  | b. COUNTY              | n: Residence before | oderjesion)                          |
|---|---|----------------------------|---|---------------------------------------|------------------------|---------------------|--------------------------------------|
| RURAL analygive neary   | acrasna   | c. LENGTH OF STAY IN       | 1 16 C. CITY OR TO                                | OWN of outside corpo                  | crate limits, write RU | RAL and give neare  | ist lawn)                            |
| d. NAME OF HOSPITAL ( OR INSTITUTION  | If nat in hospital, give street   | address)                   | Popla   | Notice,                               | adar                   | Pond                | IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                     | Roy   | EUGEN                      | E BEZIM   | DATE OF DEATH                         | 00[00]                 | Doy /2              | Yeor 1960                            |
| MALE  | WHITE WIDOW   |                            | 1 JULY 19   | 1911                                  | last birthday)         |                     | Hours Min.                           |
| SHIP FITTERS NAME   | Give kind of work dane 10b.<br>life, even if retired                          | AST GUA                    | R.D. 14. MOTHER'S                                 | MRYLA                                 | auntry)                | 12. CITIZEN OF W    | vhat country?                        |
| RoyE  | ZLSWORTH  | BEZIM                      | 17. INFORMANT                                     | 51E 19                                | OCH                    |                     |                                      |
| 15. WAS DECEASED EVER IN<br>[Yes. no. or unknown] [If ye                      | is, give war or dates of service)   | SOCIAL SECURITY NO.        | MRS EN  | W BEZI                                | in Ph                  | SADEN               | A.M.                                 |
| PART I. DEATH   | (Enter only one cause per li<br>WAS CAUSED BY:<br>MEDIATE CAUSE (a)<br>DUE TO | ine for (a), (b), and (c). | rowary  | three                                 | Arsis                  | INTERIONSET         | VAL BETWEEN T AND DEATH              |
| Canditions, if any, gave rise to immecause (a), stating the lying cause last. | ediate (  | - 0.98 + 1.57              |   |                                       |                        |                     |                                      |
| PART II. OTHER  | SIGNIFICANT CONDITIONS  | CONTRIBUTING TO DEAT       | H BUT NOT RELATED TO                              | THETERMINAL DISEAS                    | SE CONDITION GIVE      |                     | WAS AUTOPSY PERFORMED?               |
| 200. ACCIDENT WAS U<br>OR CONTRIBUTING []<br>(IF EITHER, NOTIFY MEI           | CAUSE OF DEATH  | CRIBE HOW INJURY OCC       | CURRED. (Enter nature of                          | injury in Part 1 or Par               | rt II of item 18.)     |                     |                                      |
| 20c. TIME OF INJURY Hour a. m. p. m.  | While   |                            | 0e. PLACE OF INJURY (H<br>factory, street, affice | lame, farm, 20f. (Cit<br>bldg., etc.) | y ar tawn)             | (County)            | (State)                              |
| 21. I certify that (I saw the deceased  | (this he pinel) attend  | 12-16-1                    | ram   | 1950, ta_<br>atM, fram                | the causes and         |                     | t (I) (ame) last stated above.       |
| 22a. SIGNATURE  | McKughi   | in                         | M.D. ATTENDING                                    | DIRECTOR _                            | STAFF<br>PHYS.         | July                | 22b. DATE SIGNED                     |
| 22c. PHYSICIAN'S<br>NAME (Type)   | R.M.MICLA   | 4GHLIN                     | 3-708/  | PERMAI                                | VRd. C                 | Pelsa de            | 19, Md                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)                                     | 23b. DATE THEREOF 7/15/60   | 23c. NAME OF CEMET         | . Chen, / Va                                      | 28-77                                 | TION (City, town, o    | r caunty)           | (State)                              |
| 24 FUNERAL DIRECTOR'S SI<br>McCully Fun                                       | - 11  | ADDRESS<br>O E. Fort A     | VO. 4 30  | 250. REC'D BY REGIS                   | 0.0                    | TRAR'S SIGNATURE    | 1                                    |

TO HOSP IL OR ATTENDING PHYSICIAN: The last requires that the districted be executed within 2st may be sined by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cumpletely filled page 3 should be detached for use as the burial-transit permit. Then please remark-carbs papers. Pages the State Board of Health prior to burial, cremation, ar remaval, and in any event, within 72 hours after death. VR A15 (4) 15M 9/59

rs after death. Page 4

functal director,

one completely filled in by the

anni Unadel Wayland door burter rund Fed how II years sural President Transmit Rober Holy licha, Norad 1946 14 10 कि 16 कि 141 में उत्तरिष भेड़ 3 HIP FITTER US COIDE GUARD MARRYLAND US KOY ELLSWORTH EERING ELSIE HOCH 15 GOV HEE BAM BERING PROBLEMENT HE a conte Coveray thrombour 20 7/16 to

-surprise-

R. M. Marchan 3 of the sould in Co.
R. M. My Landylin So to phy in So tall in Co.
R. M. My Landyllin 30 50 51/2 a stall in Co.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

| CERT | FIC. | ATF | OF | DF4 | TH |
|------|------|-----|----|-----|----|
|      |      | N 1 | ~  |     |    |

|   | , .,   |                        | CERTIF                       | ICA     | E OF DEATH   |   |                   | 06           | 546                                     |
|---|--|------------------------|------------------------------|---------|--|---|-------------------|--------------|---|
| PLACE OF DEATH<br>o. COUNTY   | Anne Ar  | unde.                  | L MARY                       | LAND    | 2. USUAL RESIDENCE (Who o. STATE Maryla                      | , b   | . COUNTY _        |              | e admission)                            |
| RURAL and give n  | If outside corporate limit<br>earest town)<br>POLIS                  | s, write               | c. LENGTH OF STAY            | IN 1b   | c. CITY OR TOWN (IF o  | utside corporate lim                                  |                   |              | fest town)                              |
| OR INSTITUTION  | TAL (If not in hospital, gi  |                        |                              |         | d. STREET ADDRESS  |   |                   |              | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| NAME OF<br>DECEASED<br>(Type or print)  | Robert   | 1                      | Middle<br>Oswald             |         | BOTELER  | 4. DATE<br>OF<br>DEATH                                | Manth<br>July     | Day          | y Year<br>7 1960                        |
| Male Male   | Talland to   | 7. MARR                | DIVORCE                      |         | June 3, 1891   | last  | birthday) Mc      | onths Days   | Hours Min.                              |
| during most of war  | ON (Give kind of work di<br>king life, even if retired)<br>CO Farmer |                        | KIND OF BUSINESS C<br>Tenent | R INDUS | TRY 11. BIRTHPLACE (Stote Maryla)                            | nd  |                   |              | WHAT COUNTRY                            |
|   | Lyn Botele   | -                      |                              |         | Margaret   |   |                   |              |   |
|   | ER IN U. S. ARMED FOR( (If yes, give wor or dates of se              |                        | SOCIAL SECURITY NO           |         | abel I. Bot  | teler-Sa  | Address           | Item         | #2.                                     |
|   | the under-   | Ce                     | rebrol ai                    | tuy.    | Lumboris   |   |                   | ONS          | A AND DEATH                             |
| <u> </u>  |  |                        |                              |         | NOT RELATED TO THE TERM!                                     |   |                   | IN PART 1(0) | 9. WAS AUTOPSY<br>PERFORMED?<br>YES NO  |
| OR CONTRIBUTING   | G CAUSE OF DEATH<br>MEDICAL EXAMINER)                                |                        |                              |         | . (Enter nature of injury in I                               |   |                   |              |   |
| Hour o.m.   | RY Month, Doy, Yed   | while                  | Nat while of work            |         | CE OF INJURY (Home, form<br>lory, street, office bldg., etc. |   | n]                | (County)     | (State                                  |
| 21. I certify the<br>saw the decea<br>220. SIGNATURE<br>22c. PHYSICIAN'S<br>NAME (Type) | Richard N.   | ly-6<br>)<br>/<br>Peel | Veelu                        | that de | 22d ADDRESS  121 Cather                                      | M, from the c<br>A.M.<br>RECTOR D STA<br>RECTOR D PHY | rauses and co     | on the date  | stated abave<br>22b. DATE<br>7-7-101    |
| 3a. BURIAL, CREMATIC<br>REMOVAL (Specify<br>Burial                                      | 7/11/6   | )                      | Christ                       |         | ch Cemeter   | 7 Clir  | City, town, or co | ounty)<br>Md | (State)                                 |

Church Cemetery

250. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Christ

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Md.
Ritchie Bros. Fun'l Home-Upper Marlboroff

may be fined by the haspital or ottending physician.

S FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in pay event within 72 hours after death. TO FUNERAL VR A15 (4) 1SM H/59

OR ATTENDING PHYSICIAN: The low requires that the death certificate be meruted within 24

TO HOSP

rs after death. Page 4

THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER. + 1 .\_--

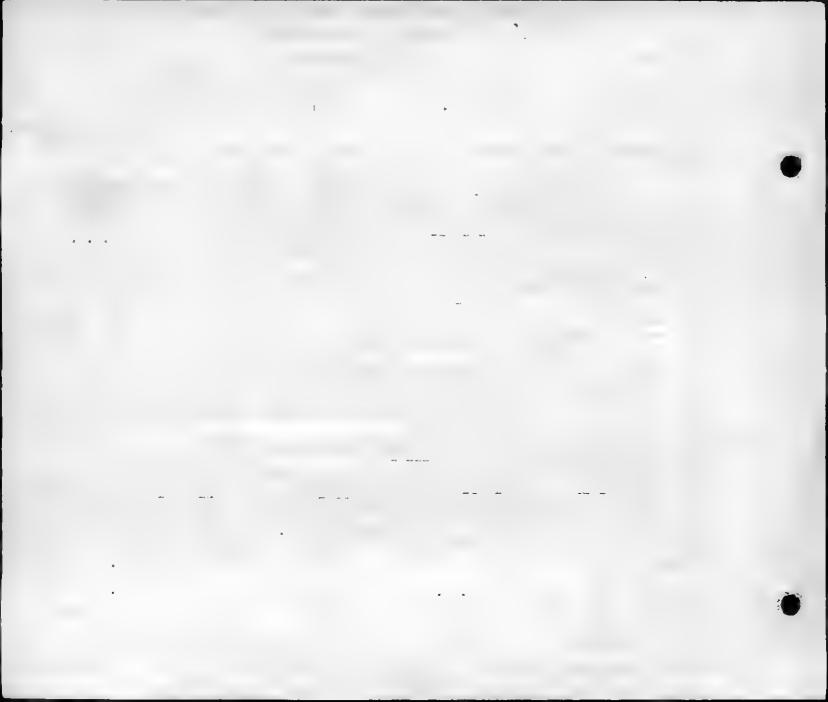
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D. 1/ MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**CERTIFICATE OF DEATH** 

Reg. Dis DN2.575

| ANTE ATUNDED  D. CITY CAI FORM IT dends copyrote limits, write  D. CITY CAI FORM IT dends copyrote limits  D. CITY CAI FORM IT dends copyrote  D. CITY CAI FORM I | 1.   | PLACE OF DEATH  o. COUNTY  |                                      |                              | 2. USUAL RESIDENCE (W            | here deceased   | l lived. If institution: Resi           | idence bef  | ore admission | 1) /    |
|--|------|----------------------------|--------------------------------------|------------------------------|----------------------------------|-----------------|---|-------------|---------------|---------|
| b. CITY OR TOWN (If ourside corporate limits, write BURAL and or given nearrest town)  CROWNSY119  CROWNSY119  CROWNSY119  CROWNSY110 State Hospital.  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street oddress)  ON NAME OF LOOPITAL (If not in hospital, give street)  Sarah Ruth Burgardner  Note of the loop to loop the loop to loop the loop th |      |                            | iel                                  | MARYLAND                     |                                  |                 | Baltimor                                | e.          |               | -       |
| C. NAME OF HOSTIAL II find in hospitel, give streat oddress)  O. NAME OF HOSTIAL II find in hospitel, give streat oddress)  OR INSTITUTION  STATE AND STATE AND BEACH ROAD  STATE AND STAT | Г    | b. CITY OR TOWN (IF        | outside carporate limits, write      |                              | 1                                | outside carpor  |   | The same of | earest town)  | 1       |
| d. NAME OF HOSPITAL (If not in happilo), give street oddress)  CTOWNSY111C State Hospital  111 Avon Beach Road  112 Avon Beach Road  113 Avon Beach Road  113 Avon Beach Road  114 Avon Beach Road  115 Avon Beach Road  115 Avon Beach Road  116 Avon Beach Road  117 Avon Beach Road  118 Avon Beach Road  119 Avon Beach Road  119 Avon Beach Road  110 Avon Beach Road  111 Avon Beach Road  111 Avon Beach Road  112 Avon Beach Road  113 Avon Beach Road  113 Avon Beach Road  114 Avon Beach Road  115 Avon Beach Road  115 Avon Beach Road  116 Avon Beach Road  117 Avon Beach Road  118 Could Coccupation (love kind of work done)  118 Avon Beach Road  129 Avon Beach Road  120 Avon Beach Ro |      | T                          | · ·                                  | 3 yrs. 22 da                 | ys Turner's S                    | tation          | Ç.5                                     |             | · "           | Mills.  |
| NAME OF   First   Models   Sarah   Ruth   Bungardner   4. PATE   Moorth   7   Ris but NOT   Roll   1900     |      |                            |                                      | I oddress)                   |                                  |                 |   |             | e. IS RESIDE  | ENCE Ru |
| DECRASED (Type or prim)  Sarah Ruth Bumgardner Plan  Fremale Negro Widowed Diversed New Marked Bounds September 25,1903 5 SEX Female Negro Widowed Diversed September 25,1903 5 September  |      | Crownsvil!                 | le State Hospi                       | tal                          | 111 Avon B                       | each Ru         | oed                                     |             | YES T         | 40 🗆    |
| SETAL   SETAL   SETAL   SUBJECT   MARKIED   NEVER MARKIED   B. DATE OF BIRTH   S. DATE    | 3.   | NAME OF                    | First                                | Middle                       | Lost                             | 4. DATE         | Month                                   | C           |               |         |
| Female Negto widowed Divorced Divorced September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles Alloward C | П    |                            | Sarah                                | Ruth                         | Bumgardner                       |                 | 7                                       | 6           | 19            | 60      |
| Female Negto widowed Divorced Divorced September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles and September 25,1903 56 77, Mooths Days Hour Alloward Country Miles Alloward C | 5    | SEX                        | 6. COLOR OR RACE 7. MAR              | RIED I NEVER MARRIED         | 8. DATE OF BIRTH                 |                 |   |             |               | 24 HRS. |
| HOUSEM Te  13. FATHER'S NAME  WIlliam Hurt  Sue Stokes  William Hurt  Sue Stokes  William Hurt  Sue Stokes  William Hurt  Sue Stokes  Intervent washing life, aven if refired)  If yra, give wor of date of torred  214-24-6385  Hospital Records  INTERVAL BETWEEN  NO  INTERVAL BETWEEN  ONSET AND DEATH  DUE TO  Conditions, if ony, which gove rise to immediate to immediate course (o). Hypertensive Cardiovascular Disease  gove rise to immediate course (o). Hypertensive Cardiovascular Disease  DUE TO  Conditions, if ony, which gove rise to immediate to immediate to immediate course (o), stoling the under lying course to immediate course (o). Hypertensive Cardiovascular Disease  DUE TO  Conditions, if ony, which gove rise to immediate to immediate to immediate course (o). Stoling the under lying course to immediate course (o). The terminal disease condition given in part 1 (o) 19, was autopsy performed?  Feet III Other Significant Conditions contributing to death but not related to the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of the part of the terminal disease condition given in part 1 (o) 19, was autopsy performed?  Yes \subseteq no model of the part of th |      | Female                     | 1                                    |                              | September 25                     | ,1903           |   | ns Doys     | Haurs         | Min,    |
| HOUSEWIFE  13. FAHRE'S NAME  William Hurt  15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT  NO  18. CAUSE OF DEATH [Enter only one course per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSE BY:  PART I. DEATH WAS CAUSE (b)  DUE TO  Conditions, if any, which gave rise to immediate course (a), using live under    Due TO   D | 10   | a. USUAL OCCUPATIO         | N (Give kind of work done 10b        | . KIND OF BUSINESS OR INC    | USTRY 11. BIRTHPLACE (Stole      | e or foreign co | ountry) 12                              | CITIZEN     | OF WHAT C     | OUNTRY? |
| 13. FATHER'S NAME   14. MOTHER'S MAIDEN NAME   15. MAS DECESSED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO   17. INFORMANT   17. INFORMANT   18. CAUSE OF DEATH   Enter only one cause per line for (a), (b), and (c).   18. CAUSE OF DEATH   Enter only one cause per line for (a), (b), and (c).   18. CAUSE OF DEATH   Enter only one cause per line for (a), (b), and (c).   18. CAUSE OF DEATH   Condition. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, which gove rise to immediate but to Conditions. If only, was autopsy restricted by the conditions of the condition of the International Conditions of the Condit   | 1    |                            | ng me, even n remed)                 |                              | Virgin                           | ia              |   | U           | .S.A.         |         |
| 15. WAS DECRASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (1 year war or date of newed) 214-24-6385 Hospital Records    18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   19. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   19. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   19. COURT [MINION IN COURTED (b), and (c).]   19. COURTE (c), and an investigation of Death BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)] 19. WAS AUTOPSY PERSONAEDY YES   NO   20. ACCIDENT WAS UNDERLYING   206 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of item 18.)   19. CONTRIBUTING   CAUSE OF DEATH   206 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of item 18.)   19. CONTRIBUTING   CAUSE OF DEATH   207 PART 11 of Item 207 P | 13   |                            |                                      |                              | 14. MOTHER'S MAIDEN              | NAME ;          | ,                                       |             |               |         |
| Tree, we wishowed   No   |      | Willi                      | am Hurt                              |                              | Sue                              | Stoke           | 25                                      |             |               |         |
| No   214-24-6385   Hospital Records  |      |                            |                                      | SOCIAL SECURITY NO 17.       | INFORMANT                        |                 | Address                                 |             |               |         |
| PART I. DEATH WAS CAUSED BY:   IMMEDIATE CAUSE (a)   Cerebral Hemorrhage   |      | 200                        | 2 yes, give war or dates of service) | 14-24-6385                   | Hospital Re                      | cords           |   |             |               |         |
| PART I. DEATH WAS CAUSED BY:   IMMEDIATE CAUSE (a)   Cerebral Hemorrhage   | F    | 18. CAUSE OF DEAT          | TH   Enter only one cause per        | line for (a), (b), and (c).] | <u> </u>                         |                 |   | IN          | TERVAL BETV   | VEEN    |
| DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stating the under lying couse lost.  PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 19. WAS AUTOPSY YES   NO 20 000 CONTRIBUTING   200 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18.)  20. ACCIDENT WAS UNDERLYING   200 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18.)  20. ACCIDENT WAS UNDERLYING   200 DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18.)  21. I Certify Month, Day, Year 200 INJURY OCCURRED of White   200 PLACE OF INJURY (Home, form, p. m. 19 of work   21 of work   21 of work   21 of work   22 of work   23 of work   24 of work   24 of work   25 of work, state)  22. I Certify that I attended the deceased from   5/14   1957, to 7/6   1960, that I last saw the deceased alive an   1/6  |      | PART I. DEAT               | H WAS CAUSED BY:                     |                              | amonnia na                       |                 |   | 101         | ISET AND D    | EATH    |
| Conditions, if ony, which gave rise to immediate coure (a), stating like under-lying couse lost.  Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES DO ACCIDENT WAS UNDERLYING DO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.)  OR CONTRIBUTING DO ACUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  OR CONTRIBUTING DO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.)  OR CITIME OF INJURY Month, Day, Year 20d INJURY OCCURRED white Dot work of  |      | 4/60                       |                                      | Octeniar III                 | smor inage                       |                 |   |             |               |         |
| gove rise to immediate couple (c), stating the underlying couple 10.    Part II Other SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? PERFORMED? YES   NO   PERFORMED? YES   NO   PERFORMED? YES   NO   NO   PERFORMED? YES   NO   NO   NO   NO   NO   NO   NO   N  |      | Conditions if on           | 223 288                              | mantangira Car               | ediousemler I                    | rigongo         |   |             |               |         |
| PART    OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 (a) 19. WAS AUTOPSY PERFORMED? YES    NO    OR ONTRIBUTING    200. ACCIDENT WAS UNDERLYING    200 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part    of item 18.)    OR CONTRIBUTING    CAUSE OF DEATH    OR ONTRIBUTING    O   |      | gave rise to in            | mediate (                            | her remarks own              | ratovascular r                   | Thease          |   |             |               |         |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.)  200. ACCIDENT WAS UNDERLYING OF DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.)  200. CONTRIBUTING OF CAUSE OF DEATH ITEM PROPERTY OF COUNTRY (Home, form. 20f. (City or lawn)  201. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED work of w |      |                            | ne under-                            |                              |                                  |                 |   |             |               |         |
| 200. ACCIDENT WAS UNDERLYING   20b DESCRIBE HOW INJURY OCCURRED. (Enter nature at injury in Part 1 or Part 11 of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH   20b DESCRIBE HOW INJURY OCCURRED. (Enter nature at injury in Part 1 or Part 11 of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH   20c PLACE OF INJURY (Home, farm. 20f. (City or lown) (County) (Stote)  Hour o. m. 19   Or   19   Or   Order   O | z    |                            |                                      | CONTRIBUTING TO DEATH B      | IIT NOT BELATED TO THE TERM      | AINAI DISEASE   | CONDITION GIVEN IN                      | PART I(a)   | 10 WAS ALL    | TOPSY   |
| 200. ACCIDENT WAS UNDERLYING   20b DESCRIBE HOW INJURY OCCURRED. (Enter nature at injury in Part 1 or Part 11 of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH   20b DESCRIBE HOW INJURY OCCURRED. (Enter nature at injury in Part 1 or Part 11 of item 18.)  OR CONTRIBUTING   CAUSE OF DEATH   20c PLACE OF INJURY (Home, farm. 20f. (City or lown) (County) (Stote)  Hour o. m. 19   Or   19   Or   Order   O | 18   | 1200                       | ER SIGNITIONITY CONDITIONS           | CONTRIBOTINO TO DEATH B      | or nor keeping to the real       | WITH D. JEAGE   | CONDITION ON EN IN                      | AKT 1(0)    | PERFORA       | AED?    |
| 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURED White of wark of foctory, street, office bldg, etc.)  21. I certify that I attended the deceased from 6/14 1957, to 7/6 1960, that I last saw the deceased alive an 7/6 1960, and that death accurred at 5:45A. M, from the causes and on the date stated above.  ACTUAL SIGNATURE CONNECTION IN DATE SIGNED M.D. Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)  L. Benedict, M.D. Crownsville State Hospital, Md. 7/6/60  220 BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMSTERY OR CREMATORY 12d 10GATION (City, town, or county) 15tate)  23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS (SIGNATURE)  240. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE  |      |                            | LINDERLYING ET 20h DE                | SCRIBE HOW INTERPLOCATE      | DED (Enter nature of injury in   | Part Los Part   | II of item 18 )                         |             | 1E2 []        | NO IN   |
| 21. I certify that I attended the deceased from 6/14 , 1957, to 7/6 , 1960, that I last saw the deceased alive an 7/6 , 1960 , and that death accurred at 5:45A. M, from the causes and on the date stated above.  ACTUAL SIGNATURE   CLUCKLEFT   DATE SIGNED   SIGNATURE   CLUCKLEFT   Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)   L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  220 BURIAL CREMATION   22b. DATE THEREOF   Z2c. NAME OF CEMSTERY OF CREMATORY   22d LIGATION (City. town, or county)   (State)   THOUGH (Specify)   T-16-40   Mf. Calkery Com-   H. H- Co- M d.   23 FUNERAL DIRECTOR'S SIGNATURE   ADDRESS   24a. REC'D BY REGISTRAR'S SIGNATURE   | CERT | OR CONTRIBUTING            | CAUSE OF DEATH                       |                              | Execution and the second in      |                 | , o , , , , , , , , , , , , , , , , , , |             |               |         |
| 21. I certify that I attended the deceased from 6/14 , 1957, to 7/6 , 1960, that I last saw the deceased alive an 7/6 , 1960 , and that death accurred at 5:45A. M, from the causes and on the date stated above.  ACTUAL SIGNATURE   CLUCKLEFT   DATE SIGNED   SIGNATURE   CLUCKLEFT   Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)   L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  220 BURIAL CREMATION   22b. DATE THEREOF   Z2c. NAME OF CEMSTERY OF CREMATORY   22d LIGATION (City. town, or county)   (State)   THOUGH (Specify)   T-16-40   Mf. Calkery Com-   H. H- Co- M d.   23 FUNERAL DIRECTOR'S SIGNATURE   ADDRESS   24a. REC'D BY REGISTRAR'S SIGNATURE   | 13   | 20c. TIME OF INJURY        | Month, Day, Year 20d                 | INJURY OCCURRED 20e          | PLACE OF INJURY (Home, for       | m. , 20f. (City | or lown)                                | (County     | ()            | (Stote) |
| 21. I certify that I attended the deceased from 6/14 , 1957, to 7/6 , 1960, that I last saw the deceased alive an 7/6 , 1960 , and that death accurred at 5:45A. M, from the causes and on the date stated above.  ACTUAL SIGNATURE   CLUCKLEFT   DATE SIGNED   SIGNATURE   CLUCKLEFT   Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)   L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  220 BURIAL CREMATION   22b. DATE THEREOF   Z2c. NAME OF CEMSTERY OF CREMATORY   22d LIGATION (City. town, or county)   (State)   THOUGH (Specify)   T-16-40   Mf. Calkery Com-   H. H- Co- M d.   23 FUNERAL DIRECTOR'S SIGNATURE   ADDRESS   24a. REC'D BY REGISTRAR'S SIGNATURE   | VED. | Haur o. m.                 | While                                | CHIEF                        | factory, street, affice bldg , e | lc ) !          |   |             |               |         |
| alive an 7/6 , 19 60 and that death accurred at 5:45A. M, from the causes and on the date stated above.  ADDRESS (Street, city or town, state)  ACTUAL SIGNATURE  Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)  L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  22a BURIAL, CREMATION. 22b. DATE THEREOF  PHYSICIAN'S NAME (Type)  22c. NAME OF CEMETERY OR CREMATORY  PHYSICIAN'S NAME (Type)  ADDRESS (Street, city or town, state)  ADDRESS (Street, city or town, state)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL, Md. 7/6/60  22d BURIAL, CREMATION. 22b. DATE THEREOF  PHYSICIAN'S NAME OF CEMETERY OR CREMATORY  ADDRESS (Street, city or town, state)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)  ACTUAL STATE HOSPITAL (City, town, or county)  ADDRESS (Street, city or town, state)   | 1    |                            |                                      | 6/14                         | . 19 57 . to                     | 7/6             | 19 60 that                              | t I last :  | saw the de    | eceased |
| ACTUAL SIGNATURE ACCUMENTS L. Benedict, M.D. Crownsville State Hospital, Md. 7/6/60  PHYSICIAN'S NAME (Type)  L. Benedict, M.D. Crownsville State Hospital, Md. 7/6/60  Zaa Burial Cremation 22b. Date Thereof Z2c. Name of Cemstery or Crematory 22d location (City. town, or county) (State)  The Collision Com-  Zab Registrar's Signature  ADDRESS (24a. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE  |      | 1 7 /                      |                                      |                              |                                  | M. from         | the causes and o                        | n the d     | ate stated    | ahove   |
| PHYSICIAN'S L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  22a BURIAL CREMATION. 22b. DATE THEREOF TEMPOVAL (Specify) 7-10-40 Mf. Column Com. (State) ADDRESS (24a. REC'D BY REGISTRAR'S SIGNATURE)  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS (24a. REC'D BY REGISTRAR'S SIGNATURE)  |      |                            | 11                                   |                              |                                  |                 |   |             |               |         |
| PHYSICIAN'S L. Benedict, M. D. Crownsville State Hospital, Md. 7/6/60  22a BURIAL CREMATION. 22b. DATE THEREOF TEMPOVAL (Specify) 7-10-40 Mf. Column Com. (State) ADDRESS (24a. REC'D BY REGISTRAR'S SIGNATURE)  23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS (24a. REC'D BY REGISTRAR'S SIGNATURE)  |      | ACTUAL                     | 6 Ruele                              | 14                           | Crownsvil                        | le Sta          | te Hospital.                            | . Md.       | 7/6           | /60     |
| 220 BURIAL CREMATION 22b. DATE THEREOF 22c. NAME OF CEMSTERY OR CREMATORY 22d LOGATION (City. town, or county) (State)   |      | SIGNATURE                  | 14000000                             | 5                            | _ M.D                            |                 |   |             |               | ٤       |
| 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS / 240. REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE  |      | PHYSICIAN'S<br>NAME (Type) | / L. Benedic                         | et, M. D.                    | Crownsvil                        | le Sta          | te Hospital,                            | , Md.       | 7/6           | /60     |
|  | 22   | MEMOVAL (Specify)          | - 1 1 1 ·                            | 11/1//                       |                                  | 22d LOCAT       | 11 11 2.1                               | d.          | (State)       |         |
| Sharles B. Lewis 1639 N. Beditchward DATEN 8 160 C. Jun 8. Kins  | 23   | FUNERAL DIRECTOR'S         | SIGNATURE                            | / /                          |                                  | D BY REGIST     | 1                                       |             |               |         |
|  |      | parles 1                   | 3. Lewis 10                          | 39 N. BEDUNU                 | DATES                            | 8 '60           | C. J. m &                               | 8. Fran     | A             |         |



## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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| 1                | X         |  |
|------------------|-----------|--|
| sciar,           | 1         |  |
| funeral director |           |  |
| funer            | should be |  |
| ę.               | <u>ē</u>  |  |

urs after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death herificate Le exemited within many that the hospital ar altending physician

TO FUNERAL DIRECTER: After this perfection has been signed by the attending physician and completely filled in by page 3 shauld be detached for use as the burial-transit permit. Then please remaye comes pages. Pages I and 2 page 3 shauld be detached for use as the burial-transit permit. Then please remaye comes pages. Pages I and 2 page 3 shauld be detached for use as the burial, crematian, ar remayal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

|          | •   | => ()                          |                                  | CERTIFI                          | CAIL          | OF DEA                               | AIH                    |                                 |                | 0000                      | ()                        |
|----------|---|--------------------------------|----------------------------------|----------------------------------|---------------|--------------------------------------|------------------------|---------------------------------|----------------|---------------------------|---------------------------|
| 1.       | PLACE OF DEATH<br>o. COUNTY                               | Anne                           | Arundel                          | MARYL                            |               | o. STATE                             | CE (Where decease      | ed ived, If institu<br>b. COUNT | ry ,           | before odmis              |                           |
|          | b. CITY OR TOWN (I<br>RURAL and give no<br>Annapo         | earest lawn)                   | porate limits, wr te             | c. LENGTH OF STAY II             | N 1b          | CITY OR TOW                          | /N (If outside corp    |                                 |                |                           |                           |
| A        | d. NAME OF HOSPIT<br>OR INSTITUTION<br>MME Arunde         |                                |                                  |                                  |               | d. STREET ADDI                       |                        | -583                            |                | e. IS RES                 | A FARM?                   |
| 3.       | NAME OF<br>DECEASED<br>(Type or print)                    | Hen                            | Fin<br>ryetta '                  | WAGNER                           | CA            | Last<br>RPENTER                      | 4. DATE<br>OF<br>DEATE | -                               | anth           | Doy<br>13                 | Year<br>19 60             |
| _        | sex<br>'emale   | 6. COLOR                       |                                  | RIED NEVER MARRIED               |               | -21-                                 | 1911                   | 9 AGE (In year<br>lost buildoy) | ) Months [     | YEAR IF UND<br>Days Hours | Min                       |
|          | JEACH   | ON (Give kin<br>king life, eve | n if retired)                    | KIND OF BUSINESS OR              | 1065          | Aria                                 | (State or foreign      | country)                        | 12.CITIZ       | U.S.                      | LOUNTRY?                  |
|          | THOM.   | -                              | WAGN                             | ER                               | (             | DA J                                 | OSEPHI)                | UE W                            | RigH-          |                           |                           |
|          | WAS DECEASED EVE  |                                | RMED FORCES? 16                  | SOCIÁL SECURITY NO.              | 17 INFOR      | MAS                                  | PCAR                   | PENTE                           | R H            | -2                        |                           |
|          |   | ATH WAS CA                     |                                  | ine for (0), (b), and (c).)      | non           | ele Cos                              | 1                      |                                 |                | ONSET AND                 | ETWEEN<br>DEATH           |
|          | Conditions, if a  |                                | DUE TO (b)                       | Laciro                           | wa            | ok                                   | ALRO                   | 0-/                             |                | 3/20                      | K.I.                      |
| 7        | lying cause last.   |                                | (c)                              | CONTRIBUTING TO BEA              | T() 01/T 1/07 | <i>V</i>                             |                        | 45 COMPUTION 6                  | O CALLED DA PT | 1/ 1/20 24/25             | AUTOPSY                   |
| FICATION |   |                                |                                  | CONTRIBUTING TO DEA              |               |                                      |                        |                                 | NEN IN PAX     | PERFC<br>YES              | ORMED?                    |
| AL CERTI | 20th ACC DENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY |                                |                                  | SCRIBE HOW INJURY OC             | <u> </u>      |                                      |                        |                                 |                |                           |                           |
| MEDICA   | 20c. TIME OF NJUR<br>Haur a.m.                            | lY Manth,                      | Doy, Year 20d.<br>While<br>at wo | Not while                        |               | OF INJURY (Mon<br>street, affice blo |                        | ry ar tawn)                     | (Cc            | ounty)                    | (State                    |
|          | saw the decea   |                                |                                  | ded the deceased to 3, 1960, and |               |                                      |                        | July 13,                        |                | O, that (I) (             |                           |
| 1        | 220 SIGNATURE   | AL.                            | there                            | 4                                | МD            | ATTENDING PHYS                       | MED. DIRECTOR          | STAFF PHYS                      |                | 7/3                       | B DATE<br>SIGNED<br>L4/60 |
|          | 22c PHYSIC AN'S NAME (Type)                               | James                          | R. Marti                         |                                  |               |                                      | w St., Ar              |                                 | ~              |                           |                           |
| 23       | REMOVAL (SEMATIC  | 7-                             | 16-1960                          | FORT L                           |               | LN                                   | PR                     | NCE G                           | EORGI          | = Co. (Sto                | Mo                        |
| 24       | JOHN A  | 1. TA                          | YLDRIS.                          | ON ANNAI                         | POLIS         | 1/                                   | O. REC'D BY REGIS      | 1 - 0 - 0                       | CISTRAR'S SIG  | Kuna                      |                           |



MARYLAND STATE DEPARTMENT OF HEALTH 708 RTIFICATE OF DEATH 8-15-61 DUSTIAL RESIDENCE (Where deceased lived If institution Residence before admission) PLACE OF DEATH FilmG269 a. COUNTY a. STATE MARYLAND Anne Arundel Anne Arundel Marvland b CITY OR TOWN (If autside carporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) RURAL and give nearest tawn) Annapolis d NAME OF HOSP TAL (If not in haspital, give street address) STREET ADDRESS OR INSTITUTION Anne Arundel General Hospital NAME OF DATE First Middle Month DECEASED OF Poges (Type or print) DEATH COLBERT July Elerv 5 SEX 6 COLOR OR RACE 9 AGE (in years IF UNDER TYEAR IF UNDER 24 HRS 7 MARRIED T NEVER MARRIED B. DATE OF BIRTH 1902 last bigthday) Manths Days Male DIVORCED [ Negro WIDOWED | popers. 100 USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHP ACE (State 12, CITIZEN OF WHAT COUNTRY? during most of worky@ life, even if retired) Maryland puo 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME physicion гетоув 17 INFORMANT attending p 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) 급 DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate Peri DUE TO cause (a), stating the underlying cause last been si bur al-transit PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Day, Year 20d INJURY OCCURRED 20s. PLACE OF INJURY (Hame, farm, 20f (City or town) factory, street, affice bldg etc. Haur a.m. Not while at work at work 21 I certify that (1) (this haspital) attended the deceased fram July 23, \_\_\_\_, 19 60 to \_July 25, \_\_ 19 60, that (1) (Was last saw the deceased alive an July 25 1960, and that death accurred at \_\_\_\_ M, from the causes and an the date stated above DIRECTOR: 220 SIGNATURE 7:20 PM. ATTENDING MED STAFF PHYS D RECTOR PHYS -M D 22c PHYSICIAN'S 22d. ADDRESS NAME (Type) TO FUNERAL 62 Cathedral St., Annapolis, Md. A. T. Allen 23a BURIAL, CREMATION, 23b. DATE THEREOF 23 JOCATION (City, tawn, ar county) 23c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 250 REC'D BY REGISTRAR 256 REG STRAR'S SIGNATURA

e. IS RESIDENCE

Hours

NTERVAL BETWEEN

PERFORMED? YES NO IX

(State)

22b DATE S GNED

U.S.

(County)

arthur & Krases

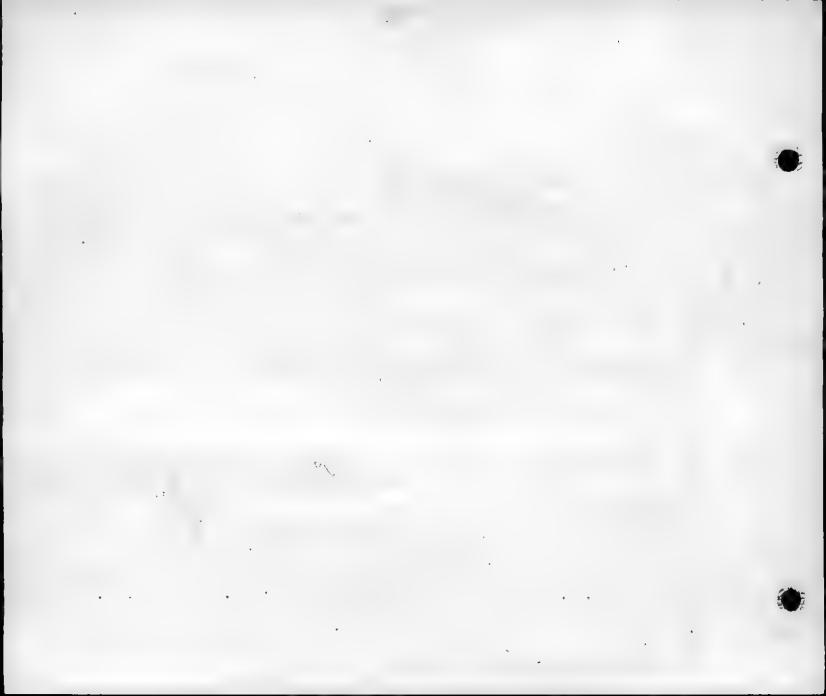
DATEJUL

ON A FARM?

YES NO R

Year

1960



VS A15 (4) 15M 9/55

| 3. NAME OF DECEASED (Type or p | and 2 should be filed with | 1. PLACE OF COUNT Anne COUNT Anne COUNT OF RURAL COUNT OF INSTEAD OR INST |
|--------------------------------|----------------------------|---|
|                                | Pages 1 and                | DECEASED  |
|                                | per.                       | 100 USUAL C   |

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7625

**CERTIFICATE OF DEATH** 

07578 Reg. Dist. No.

|  | Anne Arur  | ndel  |           |          | MARY         | LAND               | 2. USUAL RESIDENCE (W<br>a STATE<br>- Maryland | /here decease         | b. COUNTY                       |             |           | <u>admissia</u> | in)      |
|--|--|---|-----------|----------|--------------|--------------------|--|-----------------------|---------------------------------|-------------|-----------|-----------------|----------|
|  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest fawn)  2 Vears  |   |           |          |              | c CITY OR TOWN (IF | outside corpo                                  | orate limits, write R | URAL and g                      | ive neares  | si lown)  |                 |          |
|  | Crow sville 5 mo. 13 days  |   |           |          |              | Federals           | burg,  | 1 1                   | - 1                             | 7           | 1         |                 |          |
|  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   |           |          |              | d. STREET ADDRESS  |  |                       | ð                               | 0.          | IS RESID  | ENCE            |          |
|  | Crownsvil  | Lle State 1                                   | Hospi     | tal      |              |                    | Unknown  |                       |                                 |             |           | rES 📋           |          |
|  | NAME OF<br>DECEASED  | Fi  | rst       |          | Middle       |                    | Lost   | 4. DATE               | Mor                             | ilh         | Doy       |                 | POF      |
|  | (Type or print)  | Rose  | 9         |          | Lee          |                    | Collins  | DEATH                 | 7                               |             | 6         | 19              | 60       |
| 5. 5   | SEX  | 6. COLOR OR RACE                              | 7 MARI    | RIED 🔲 N | NEVER MARRIE | D 🔲                | 8 DATE OF BIRTH                                |                       | 9. AGE (In years last birthday) | IF UNDER    |           |                 |          |
|  | Female   | Negro   | WIDOW     | ED 🔣     | DIVORCE      |                    | 1884   |                       | 75 yn.                          | Months      | Days F    | dours           | Min      |
| 100  | USUAL OCCUPATIO  | N (Give kind of working life, even if retired | dane 10b. | KIND OF  | BUSINESS O   | R INDU             | STRY 11. BIRTHPLACE (Stat                      | e or fareign c        | ountry)                         | 12 CITI     | ZEN OF    | WHAT (          | OUNTRY?  |
|  | Domestic   | ing lite, even it retired                     | "         |          |              |                    | Maryl  | and                   |                                 |             | U.S.A     | A.              |          |
| 13.  | FATHER'S NAME  |   |           |          |              |                    | 14 MOTHER'S MAIDEN                             | NAME                  |                                 |             | *         |                 |          |
|  | Unknown  |   |           |          |              |                    | Tissa  | ?                     |                                 |             |           |                 |          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address |  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| (Tex   | No (If yes, give wor or dote of service) Unknown Hospita: Records  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | PART I. DEATH WAS CAUSED BY: Sontinemia  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | DUE TO   |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | Conditions, if any, which gave rise to immediate Decubital Ulcers  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  |  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | cause (a), stating the under. DUE TO   |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| Z  |  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| NA.  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPST PERFORMED?  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| F  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19. WAS AUTOPSY PERFORMED?  YES NO  OR CONTRIBUTING CAUSE OF DEATH  OR CONTRIBUTING CAUSE OF DEATH  OF CONTRIBUTING CAUSE OF DEATH |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| C.R.   | GOR CONTRIBUTING CAUSE OF DEATH  W [IF EITHER, NOTIFY MEDICAL EXAMINER]  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  |  |   |           |          |              |                    |  | (State)               |                                 |             |           |                 |          |
| AED  | Hour a.m. While Not while factory, street, office bldg., etc.)   |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
| 2  | 3/07 50 5/   |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  |  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | alive on 7/6, and that death accurred at 3:30P. M, from the causes and an the date stated above.  ADDRESS (Street, city or lawn, state)  PATE SIGNED   |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | ACTUAL Ch. M. M. M. Miller and M.  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |
|  | SIGNATURE NEE  | Provide AFC                                   | O (D) F   | O 1/ V   | //           |                    | MD. CTOWNSVII.                                 | Te Dia                | re moshim                       | A Bless     | y J. 241. |                 | 17.17.50 |
|  | PHYSICIAN'S<br>NAME (Type)   | Hildegard                                     | Hear      | l Rei    | .ssman,      | M.I                | . Crownsvil                                    | le Sta                | te Hospit                       | al Ma       | rylar     | ıd              | 7/7/60   |
| 220  | BURIAL, CREMATION ROMAN (Specify)  | N. 226. DATE THERE                            | 60        | 22c, N   | AME OF CEME  | ETERY O            | P. CPEMATORY DIAWARD                           | 228. LOCA             | TION (City Town,                | or county)  | Pre       | (State)         | land     |
| 23.  | FUNETAL DIRECTOR'S   | SEGNATURE                                     | 1/1       | V IN     | DRESS 4      |                    | <i>f-(,' ,   ,   )</i>                         | D BY REGIS            |                                 | STRAR S SIG |           | /               |          |
| ·  | Will Klist I 108 W. Wark of grandbary 1 9'ou Cillar ? The  |   |           |          |              |                    |  |                       |                                 |             |           |                 |          |



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# FOR STATE HEALTH DEPT please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO PUNEMAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Boar- of Health, or its designated agent, prior to burial, cremation, or removal, and it any event within 72 hours after death.

VS. ATSME 5M 7/59

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARCA

|   | 1. PLACE OF DEATH  |                               | 2 HOURT DECIDENCE When decide  | id I ved, If institutions Residence before edmission)  |
|---|--|-------------------------------|--|--|
|   | a COUNTY   |                               | e. STATE   | b. COUNTY  |
| 1 | Anne Arundel.  | MARYLAND                      | Maryland   | Anne Arundel   |
| V | b. CITY OR TOWN (if ou side corporate limits, write RURAL and give neerest town) | c. LENGTH OF STAY IN 16       | c. CITY OR TOWN (if oulside corporete  | limits, write RURAL and give nearest town)   |
| 4 | Annanolis  |                               | Annapolis  |  |
|   | d. NAME OF HOSPITAL OR INSTITUTION (if not in hos)                               | p.lel give street eddress)    | d STREET ADDRESS   | IS RESIDENCE     ON A FARM?  |
| 1 | Anne Arundel General Hos   | oital                         | 146 Defense  | Highway YES NO X   |
| 1 | 3 NAME OF First DECEASED   | M ddle                        | Last A DATE  | Month Dey Year   |
|   | (Type or print) GEORGE   | W.                            | COOLEY / DEATH   | July 18 19 60  |
|   | 5 SEX 6. COLOR OR RACE 7. MARRIE   | D NEVER MARRIED 8             |  | E (In years IF UNDER 1 YEAR IF UNDER 24 HRS  |
|   | Male White WIDOWE  | D DIVORCED 7                  | 19401  | Months Days Hours Min.   |
|   | 10a UZUAL OCCUPATION (Give kind of work 196) KI                                  | IND OF BUSINESS OR INDUSTRE   | 11 ARTHPLACE (State or foreign country)  | 12 CITIZEN OF WHAT COUNTRY?  |
| ı | done furing most of working life, even igretired)                                | Min Bornel                    | Maryland   | 27 C 4   |
| ı | 13. FATHER NAME  | o -a vaccin                   | 14 MOTHER'S MAIDEN NAME  | 1.0.11   |
| ı | Tomas M. Con   | Pour le.                      | Police & press   | mand   |
|   | TS. WAS DECEASED EYER IN U.S. ARMED FORCES? 16.                                  | SOCIAL SECURITY NO.1 17. 3    | WEORMANT YOU'VER   | Address .  |
| 1 | (Yas, no, or unkown) (Syesgiveweror delesolservice)                              |                               | 9-10-1   | /  |
| A | 18. CAUSE OF DEATH [Enler only one cause per li                                  |                               | eorge N. Cooley  | I INTERVAL BETWEEN   |
|   | PART I. DEATH WAS CAUSED BY  |                               | •  | ONSET AND DEATH  |
|   | P 1 \ \ /  | ab Wound of Che               | st <sub>e</sub>  |  |
|   | DUE TO   |                               |  |  |
|   | Conditions, if any, which (b)  |                               |  |  |
|   | (a), stelling the underlying DUE TO  |                               |  | ,  |
|   | cause lest.  | TRIBLIT LIG TO BE ATH BUT LIG |  |  |
| J | PART I OTHER SIGNIF, CANT CONDITIONS CON   | IKIBUTING TO DEATH BUT NO.    | I KELATED TO THE TERMINAL DISEASE CONL   | PERFORMED?   |
| ı | 5  |                               |  | YES K NO   |
| 1 | PRIMARY To or CONTRIBUTING   | BE HOW INJURY OCCURED. (E.    | nter nature of injury in Part I or Part II of Itam                             | 18.)   |
| 1 |  | Stabbed in ches               |  |  |
|   | U  | f                             | CE OF INJURY (Home, form, 20f. (City or to<br>cry, street, office bldg., etc.) | (County) (State)   |
|   | 9:00 p.m. 7/18 1960 of world   |                               | House Annap  | olis Anne Arundel Md.  |
|   | 21 I certify that I took charge of the rem                                       | ains described above, hel     | d an Autopsy 🗶. Inspection 🔲.  | Inquiry, and in my opinion   |
|   | death resulted from: Natural causes  | Accident . Suicid             | de 🔲, Homicide 📆, Undete   | rmined manner  |
|   |  | 1                             | CHIEF MEDICAL EXAMINER   |  |
|   | SIGNATURE CALLS J.   | /ck2:                         | M.D. ASSISTANT MEDICAL EXAMINER  | DATE SIGNED  |
| 1 | EXAMINER'S   | 03                            | DEPUTY MEDICAL EXAMINER  | 7/19/60  |
|   | NAME (Type) Charles S. F   | etty, M.D.                    | Address (Street, city, town or count   | y)   |
|   | 220. BURIAL, CREMATION, 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR      | CREMATORY 3 22d. LOCATION  | (City, town, or country) (Slete)   |
|   | 12mal 17-22-1960   | Hillerest                     | Mamourd Com  | repoles me   |
|   | 23. AUNERAL DIRECTOR SCHOOL SCHOOL   | ADDRESS                       | P. 1110  | 24b. BEGISTRAR'S SIGNATURE   |
|   | gram of sugar con  | mujec                         | 1/C DAUL 21 '60  | arthur S. Kraus  |
| 1 | 7  |                               |  | And the state of t |



VS A1S (4) 15M 10/SZ

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7628 CERTIFICATE OF DEATH

07582 Reg. Dist. No.

| ١,   | o. COUNTY Anne Aru   | ndel   |                  | MARY                     | LAND      | 2. USUAL RESIDE     | DENCE (Wh   |                 | lived If institute  b. COUNTY      | on Residenc                           | e before i | <u>adm</u> (35) | on)              |
|--|--|--|------------------|--------------------------|-----------|---------------------|-------------|-----------------|------------------------------------|---------------------------------------|------------|-----------------|------------------|
| Г  | 6. CITY OR TOWN (IF  | outside corporate limi                         | ts, write        | c. LENGTH OF STAY        | IN 1b     |                     | OWN (IF o   |                 | Samo<br>ole limils, write R        | URAL ond g                            | ive negres | sl lown         | )                |
|  | I rooklyn  |  |                  | Over 6 ye                | ars       | Sa me               |             |                 | P,                                 |                                       |            |                 |                  |
| Г  | d. NAME OF HOSPITA   |  | ive street       | oddress)                 | a. D      | d. STREET A         | DDRESS      |                 | 0                                  |                                       | e.         | IS RESI         | DENCE            |
|  | 901 Vict   | ory Aven <b>uu</b>                             |                  |                          |           | Same                |             |                 |                                    |                                       |            |                 | FARM?            |
| 3.   | NAME OF  | T. Fir   | sl               | Middle                   |           | Los                 | )           | 4. DATE         | Mon                                | th                                    | Day        | ١               | /eor             |
|  | (Type or print) R  | ose Cover                                      |                  |                          |           |                     |             | DEATH           | July 2                             | Oth                                   |            | 1               | 9 60             |
| S.   | SEX  | 6. COLOR OR RACE                               | 7. MARR          | IED NEVER MARRIE         | D 🔲 🖁     | DATE OF BIRTH       | 1           | 9               | P. AGE (In years<br>lost birthday) | IF UNDER                              |            |                 |                  |
|  | F  | W  | WIDOWI           | ED 🔀 DIVORCEI            |           | 11/8/98             | 3           |                 | 6] yrs.                            | Months                                | Doys H     | tours           | Mîn              |
| 10   | O USUAL OCCUPATIO  | N (Give kind of work ing life, even if relired | done 10b         | KIND OF BUSINESS O       | R INDUST  | RY 11. BIRTHPL      | ACE (Stote  | or foreign cou  | intry)                             | 12 CITI                               | ZEN OF V   | WHAT            | COUNTRY?         |
|  | Housewif   |  | '                |                          |           | Balt                | timore      | e,MD.           |                                    | USA                                   |            |                 |                  |
| 13.  | FATHER'S NAME  |  |                  |                          |           | 14. MOTHER'S        | MAIDEN N    | IAME            |                                    |                                       |            |                 |                  |
|  | ? Kres   |  |                  |                          |           | ? W:                | iegan       | đ               |                                    |                                       |            |                 |                  |
| 15.  | WAS DECEASED EVER  | IN U. S ARMED FOR                              |                  | SOCIAL SECURITY NO.      | 12, INI   | FORMANT             |             |                 | Add                                | ess                                   |            |                 |                  |
| 17.  | es, no as unknown) (I  | t yes, give war ar doles of s<br>TYO           |                  | 19-10-4576               | lis       | s Jean (            | Cover       | (daugh          | nter } 901                         | Vict                                  | ory A      | Ave             | nue #2           |
|  | 18. CAUSE OF DEAT  | TH [Enter only one co                          | use per lir      | ne for (a), (b), and (c) |           |                     |             |                 |                                    |                                       | INTERV     |                 |                  |
| PART 1. DEATH WAS CAUSED BY: Coronary Thrombosis ONSET AND DEATH THROW THE CAUSE (c) Coronary Thrombosis |  |  |                  |                          |           |                     |             | DEATH           |                                    |                                       |            |                 |                  |
|  | DUE TO   |  |                  |                          |           |                     |             |                 |                                    |                                       |            |                 |                  |
|  | Conditions, if ony, which } (b) Cardio-vascular diseases 3 years |  |                  |                          |           |                     |             |                 |                                    |                                       |            |                 |                  |
|  | gove rise to in  | mediate Dus to                                 |                  |                          |           |                     | -           |                 |                                    |                                       | -          | 500             | April 3 pt       |
|  | lying couse lost,  | ne under-                                      |                  |                          |           |                     |             |                 |                                    |                                       |            |                 |                  |
| ž  | PART II. OTH   |  | -                | ONTRIBUTING TO DEA       | TH BUT N  | OT RELATED TO       | THE TERMI   | NAL DISEASE     | CONDITION GIV                      | EN IN PART                            | 1(0) 19.   | WAS A           | UTOPSY           |
| CATION   |  |  |                  |                          |           |                     |             |                 |                                    |                                       |            | PERFO           | RMED?            |
|  | 200 ACCIDENT WAS   | UNDERLYING []                                  | 20b. DESC        | CRIBE HOW INJURY OF      | CURRED.   | (Enter noture of    | injury in P | ort I or Port 1 | Il of item 18.]                    |                                       |            |                 | 110              |
| CERTIF   | 200 ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY A      | CAUSE OF DEATH                                 |                  |                          |           |                     | ` '         |                 |                                    |                                       |            |                 |                  |
| 3  | 20c. TIME OF INJURY  |  | r 20d IN         | NJURY OCCURRED           | 20e. PLAC | E OF INJURY ()      | fome, form, | 20f. (City o    | or fown)                           | IC.                                   | ounty)     |                 | (Stote)          |
| MEDICAL  | Hour o.m.  | 19   | While<br>of work | Not while                | facto     | ory, street, office | bidg., etc. | )               |                                    | (0.                                   |            |                 | (store)          |
| 2  | p. m.  |  |                  | <u> </u>                 | 3303037   | 5/                  | Ť÷          | 17 200          | l-h 6Λ                             |                                       |            |                 |                  |
|  | 9  | at I attended the                              |                  |                          | uary      | 19 20               | , to ell    | 2117 201        | th. 1960                           | .,that I le                           | ast saw    | the             | deceased         |
|  | alive on   | ly 1 th.                                       | ــر 18 ســ       | ond that                 | death a   | accurred at         | <b>→</b>    | _M, from        | the causes a                       | nd on th                              | e date     | state           | <b>d a</b> bave. |
|  | acris 4  | 1 . 1  | 000              |                          |           |                     |             | ADDRESS (Stre   | rel, city or lown,                 | slole)                                |            | DA              | TE SIGNED        |
|  | ACTUAL SIGNATURE   | uclau /  | F 1/2 3          | ankend                   | # 36 M    | D. G.1€             | en i ur     | rnie,!%         |                                    |                                       |            |                 | 21/30            |
|  | PHYSICIAN'S<br>NAME (Type)                                       | Gustave H.                                     | Faul             | ert.M.D.                 |           |                     |             |                 |                                    |                                       |            |                 |                  |
| 220  | BUR AL, CREMATION  |  |                  | 22t. NAME OF CEME        | TERY OR   | CREMATORY           |             | 22d LOCATR      | ON (City, town, a                  | r county)                             |            | (Stote          | 1                |
|  | REMOVAL (Specify) Burial   | 7/23/60  | )                | New Cathe                |           |                     |             |                 | imore, M                           |                                       | nd         | Jarore          | ,                |
| 23,  | FUNERAL DIRECTOR'S   | SIGNATURE                                      | 1.               | ADDRESS                  | MT OT     | veme ve             | - 5/        | BY REGISTR      |                                    |                                       |            | _               |                  |
| 16   | dm. D. The   | CANCE T  | 376              | 2 17                     | n         | 8                   |             |                 |                                    | , , , , , , , , , , , , , , , , , , , |            |                 |                  |

| N. James   | 7589 CERTIFICATE OF DEATH  | Reg. Dist. No. 17583  |
|--|--|---|
| director<br>filted with  | O. COUNTY HUNE ARUNDEL MARYLAND 2 USUAL RESIDENCE (Where   | deceased lived. If institution: Residence before admission)  AND b. COUNTY Halfa Co.  |
| death<br>funeral   | b. CITY OR TOWN (If outside corporate limits, write pural on give nearest town)  AND FIDEL'S  c. LENGTH OF STAY IN The c. CITY OR TOWN (If outside Country of Country | de corporate limits, write RURAL and give nearest lown)                               |
| by the d 2 show  | d NAME OF HOSPITAL (If not in hospital, give street oddress)  OR INSTITUTION  HALF. TENERAL HOSPITAL   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO   |
| Service 1 servic | 3. NAME OF DECEASED (Type or print) CHARLOTTE MURTLE COX   | DATE Month Day Year PEATH 19 60   |
| d withir   | 5. SEX   6. COLOR OF RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   WIDOWED   DIVORCED   8-20-19/4   | 9. AGE (In years IF UNDER 1YEAR IF UNDER 24 HRS lost birthday) Months Doys Hours Min. |
| execute on pope  | 100. USUAL OCCUPATION (Give kind of work done during-most of working life, even if retired)  SECT:  MARY L   | foreign country)  12 CITIZEN OF WHAT COUNTRY?   |
| icion or softer  | 3. FATHER'S NAME! UNK "  | 1/2 is  |
| ng phys<br>re remay<br>72 hour   | 5. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes. no. or unbnown) (If yes. give wor or dates of service) (A. SOCIAL SECURITY NO. 17. INFORMANT (A. SOCIAL SECURITY NO. 17. INFORMANT (Yes. no. or unbnown)  | Cox SR. #2  |
| attendi<br>n pleas   | 18. CAUSE OF DEATH [Enter only one couse per line for (o). (b). ond (c).]  PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o).  | INTERVAL BETWEEN<br>ONSET AND DEATH   |
| that the by the it. The  | conditions, if ony, which) DUE TO Polycustie renal disc  | Care 5 years  |
| equires<br>an.<br>signed<br>sit perm   | gove rise to immediate couse (a), stating the under- lying couse lost.   |   |
| physicia<br>os been<br>ial-trans   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA   | L DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO              |
| FAN: The ending ficate the burner  | 20g. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTION CO | I or Port II of item 18 )   |
| PHYSIC<br>al or off<br>his certifuse os<br>was os<br>emotion.  | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not while of work at w | 20f (City or town) (County) (Slate)   |
| ADING<br>haspine<br>After t<br>shed for<br>rriol, cri  | 21. I certify that I attended the deceased from. 14, 1960, ta 7/2 alive an 2, 1960, and that death accurred at 6:45 P.   | 7, 1960, that I last saw the deceased W, from the causes and an the date stated above |
| ATTEN<br>by the<br>ECTOR:<br>e detact<br>or to bu  |  | DRESS (Street, city or town, stole)  DATE SIGNED  DATE SIGNED                         |
| portal on printed billing 3 should billing printed billing printed billing printed billing billing bright bright billing bright | BUVELPIA NIE   | POLIS, MID=   |
| moy moy bugge 3 s  |  | d tOCATION (City, lawn, or county) (State)  |
| VS A15 (4)   | ADDRESS 240. REC'D B   | Y REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| 15M 9/55   |  | DV Committee / Iganory  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

| 7629 MEDICAL EXAMINER'S  | CERTIFICATE OF DEATH                                      | 07584                                |
|--|---|--------------------------------------|
| ACE OF DEATH   | 2. USUAL RESIDENCE (Where decessed lived, if institution  | on, Residence before admission       |
| Anne Arundel MARYLAND  | Maryland b. COUNTY An                                     | ne Arundel                           |
| CITY OR TOWN (if outside corporate limits,   c. LENGTH OF STAY IN 1b   | c, CITY OR TOWN (If outs'de corporate limits, write RURAL |                                      |
| write RURAL end give nearest town) Shades River  | Landover  |                                      |
| NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress)  | d. STREET ADDRESS   | e. IS RÉSIDENC                       |
| Pier of Shades River   |   | YES NO                               |
| IME OF First Middle  | Last 4. DATE Month  | Day Year                             |
| CEASED  oe or print)   | OF DEATH TOTAL  | 0 10 / 0                             |
| 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.   | CRAWFORD July   | 9 19 60<br>ER 1 YEAR, IF UNDER 24 HR |
| 3  | uly 17, 1904   lest birthdey)   Month                     | Days Hours Mn.                       |
| MILL CE  |   | CITIZEN OF WHAT COUNTE               |
| furing most of working life, even if refired) Plasterer A Eberly and sons  | Washington D C. U   | SA                                   |
| THER'S NAME  | 14. MOTHER'S MAIDEN NAME                                  | .,                                   |
| William Harrison   | Elizabeth Ann Brown                                       |                                      |
| AS DECEASED EVER IN U.S. ARMED FORCES?   16, SOCIAL SECURITY NO. 17, I   |   |                                      |
| o, or unkown) (liyesgive wererdetes of service)  |   | . Ma                                 |
| CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]  | ymond L Crawford Hyattsvill                               | INTERVAL BETWEEN                     |
| PART I DEATH WAS CAUSED BY:  |   | ONSET AND DEATH                      |
| IMMEDIATE CAUSE (a) Drowning   |   | S - JA - No.                         |
| DUE TO   |   |                                      |
| ondiffons, if any, willich (b)   |   |                                      |
| ), sleling the underlying DUE TO   |   |                                      |
| USE TOST II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO   | T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN P    | ART I(a): 10 WAS ALITODS             |
| TAKE N. OTHER SIGNIFICANT CONTROL OF THE STATE OF THE STA |   | PERFORMED?                           |
| . EXTERNAL CAUSE WAS 1 20b. DESCRIBE HOW INJURY OCCURED. (E  | nter neture of injury in Pert I or Pert II of item 18.)   | YES NO                               |
| PMARY TO pr CONTRIBUTING TO 1  |   |                                      |
|  | when his boat tipped over                                 | r                                    |
| c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20e. PLA Hour 200. 10 While Not While  | pry, street, office bidg., etc.)                          | County) (State)                      |
| p.m. 7/9/ 19 60 et work st work I Shad   |   | e Arundel, Md.                       |
| . I certify that I took charge of the remains described above, he  |   | and in my opinion                    |
| eath resulted from: Natural causes , Accident X. Suici   |   |                                      |
| R 000 0 6 1  | CHIEF MEDICAL EXAMINER                                    |                                      |
| GNATURE (LUSSELL) FISHER   |   | DATE SIGNED                          |
| KAMINER'S BURGOTT & Figher MD  | DEPUTY MEDICAL EXAMINER                                   | 7/11/60                              |

NAME (Type) RUSSELL 5. Fisher, M.D. 22c. NAME OF CEMETERY OR CREMATORY

Address (Street, c'ty, town, or county) 22d. LOCATION (Clly, lown, or country)

(Steta)

Rock Creek Cemetery

Washington D C

246. REC'D BY REGISTRAR | 246. REGISTRAR'S SIGNATURE JUL 1 5 '60 arthur & Kreek

Gasch's Sons Hyattsville Md.

5M 7/59



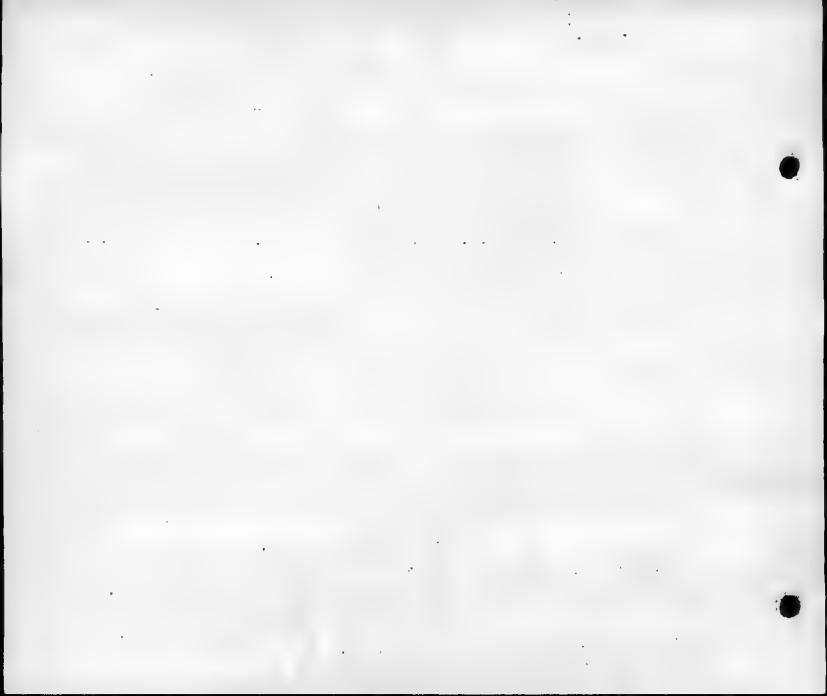
.75911

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

| L            |  | 990   |                 | CERTIFIC                | ATE     | OF DEAT                                 | H                            |                                    |            | 1175      | 185           |                                     |
|--------------|--|---|-----------------|-------------------------|---------|---|------------------------------|------------------------------------|------------|-----------|---------------|-------------------------------------|
| 1.           | PLACE OF DEATH<br>a. COUNTY  |   | 1.7             | MARYLAND                | ll l    | USUAL RESIDENCE (                       |                              | d lived. If instituti<br>b. COUNTY | on: Reside | ence befo | re admis      | sion)                               |
| H            | b. CITY OR TOWN (IF  | Anne Arur   |                 | c. LENGTH OF STAY IN 18 | _ !     | .c. CITY OR TOWN (I                     | ylane<br>Kautida sama        |                                    |            |           |               | en l                                |
|              | RURAL and give ne  | arest town)   |                 | 4 dayd                  |         | 1 .                                     | AL O Se                      |                                    | OKAL GIN   | give me   | 01631 1011    | ,                                   |
| Ai           | d. NAME OF HOSPITA<br>OR INSTITUTION<br>INC. APUNCE.                       | AL (If not in hospitot, g<br>General H                          | lospi           | address)                |         | d. STREET ADDRESS                       |                              |                                    |            |           | e. IS RES     | SIDENCE<br>FARM?                    |
| 3.           | NAME OF  | Fir   | st st           | Middle                  | -       | Lost                                    | 4. DATE                      | Mor                                | nth .      | Do        | ру            | Year                                |
|              | (Type or print)  | ilsa  |                 | Biggs                   |         | DAVIS                                   | DEATH                        | Ju                                 | ly         | 23        |               | 1960                                |
| S.           | SEX  | 6 COLOR OR RACE   | 7 MARI          | RIED NEVER MARRIED      | B D     | ATE OF BIRTH                            |                              | 9 AGE (In years<br>lost birthdoy)  | IF UNDE    | T         |               | ER 24 HR                            |
|              | Male   | White   | WIDOW           | ED DIVORCED             | De      | cember 18,                              | 1906                         | 53 yrs                             | Months     | Doys      | Hours         | Min                                 |
| 10           | d. USUAL OCCUPATIO<br>during most of work<br>Retire                        | N (Give kind of work ing life even if retired Painte            | dane 10b.       | KIND OF BUSINESS OR INI | DUSTRY  | 4.                                      | arolina                      | * *                                | 12 CI      | ITIZEN OI |               | COUNTRY                             |
| 13           | FATHER'S NAME  |   | -               | ~                       | 1.      | 4. MOTHER'S MAIDEN                      |                              | 4                                  |            |           |               |                                     |
|              | Georg  | ge ?B. Da   | vis             |                         |         | Sally                                   | F Har                        | edina                              |            |           |               |                                     |
| 15           |  | IN U. S. ARMED FOR  | CES? 16.        | SOCIAL SECURITY NO. 17  | INFOR   |   | 1 1 11001                    |                                    | lress .    |           |               | -                                   |
| [,           | Yes (  | "WW" "II" of s  | ervice 2]       | L3 18 6980              | Mrs     | Jack Er                                 | he- T                        | aughter                            | n_ a       | a.me_     | 9.0           | # "                                 |
| CATION       | Conditions, if or gove rise to in couse (a), stating the lying couse lost. | the <u>under:</u> DUE TO  |                 | CONTRIBUTING TO DEATH B |         | T RELATED TO THE TER                    |                              | E CONDIT ON G                      | AEM IM by  |           | PERFO         | AR.                                 |
| CAL CERT FIG | (IF EITHER, NOTIFY   | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Day Ye |                 | CRIBE HOW INJURY OCCUR  | PLACE   | OF INJURY (Home, fo                     | orm, 20f. (Cib               |                                    |            | (County)  |               | (Stot                               |
| MEDICA       | Hour o.m.  | 19  | While<br>at wor | k at work               | factory | , street, office bldg.,                 | etc.)                        |                                    |            |           |               |                                     |
|              | 22c PHYSICIAN'S<br>NAME (Type)   | ed alive anII   | lly 2<br>Beck   |                         | M.D     | ATTENDING PHYS TX 22d ADDRESS 71 Frankl | M, from DP • MED. DIRECTOR □ | the causes are STAFF               | is,        | he date   | stated on 7/2 | d above<br>2b DATE<br>SIGNE<br>5/60 |
|              | BURIAL CREMATION   | July 26   |                 | Glen Haver              |         | REMATORY                                | Glen                         | TION (C ry, town,<br>Burnie        |            | 1         | (Sto          | ie)                                 |
| 24<br>6      | opping an  | SER NATIVE SER  | 24              | Glen Burnie             | e , i   | 25g. RI<br>DATE                         | JUL 2                        | TRAR 25b, REG                      | STRAR'S S  | - 4       |               |                                     |

VR A1S (4) 1SM 9/59



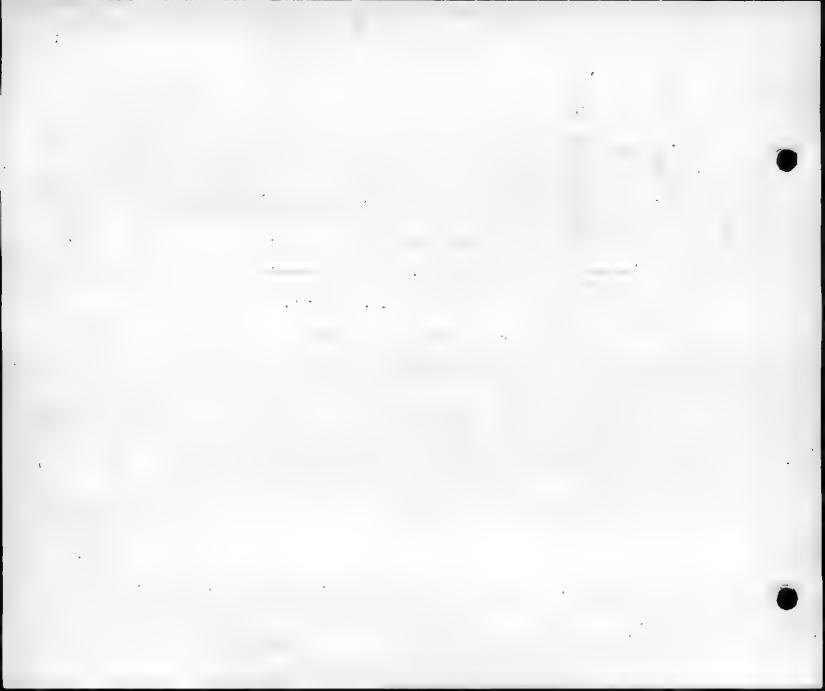
VS A15 (4) 15M 9/58

| MARYLAND | STATE | <b>DEPARTMENT</b> | OF | HEALTH-BALTIMORE, | 18 |
|----------|-------|-------------------|----|-------------------|----|
|          |       |                   |    |                   |    |

7630 CERTIFICATE OF DEATH

07586 Reg. Dist. No.

|         | LACE OF DEATH COUNTY Anno Arundel  |                      | MATRIAND           | 2 USUAL RE<br>a. STATE | Maryla:                          |                | lived. If instituti<br>b. COUNTY  |              | Aruno         |            |
|---------|--|----------------------|--------------------|------------------------|----------------------------------|----------------|-----------------------------------|--------------|---------------|------------|
|         | CITY OR TOWN (If outside corporate lim<br>RURAL and give nearest town)<br>Fort George G. Meade   |                      | GTH OF STAY IN 16  | c CITY O               | odento:                          |                | ate limits, write R               | URAL and giv | re nearest to | own)       |
| d       | NAME OF HOSPITAL (If not in hospital, or INSTITUTION   | give street address) |                    | d. STREET              | ADDRES5                          |                |                                   |              | e t5          | RESIDENCE  |
| J       | J. S. Army Hospital  |                      |                    |                        | 5th St                           | reet           |                                   |              |               | □ NO 🛛     |
| 3.      | IAME OF FI   | rst                  | Middle             | * L                    | ast                              | 4. DATE<br>OF  | Man                               | th           | Day           | Year       |
|         | Type or print) GE  | ORGE                 | PERRY              | DAWS                   | ON                               | DEATH          | J                                 | ULY          | 5             | 19 60      |
| 5. \$1  | 6. COLOR OR RACE   | 7. MARRIED           | NEVER MARRIED      | 8 DATE OF BIR          | TH                               | 9              | . AGE (In years<br>last birthdoy) | Months D     |               |            |
| 1       | MALE CAU   | WIDOWED              | DIVORCED           | Actobe                 | rt 23,15                         | <b>B</b> 91    | 65 68 yrs                         | Months       | lays Hou      | rs Min.    |
| 10a.    | USUAL OCCUPATION (Give kind of work during most of working life, even if retired   | done 10b KIND C      | F BUSINESS OR INDI | STRY 11. BIRTH         | PLACE (State o                   | or foreign cou | intry)                            | 12. CITIZE   | N OF WHA      | T COUNTRY? |
| 4       | N/A  |                      | penter             | 1                      | arylan                           | d              |                                   | U.           | S. A.         |            |
| 13 F    | ATHER'S NAME   |                      | A1986              | 14. MOTHER             | 'S MAIDEN NA                     | AME            | n                                 |              | 4             |            |
|         | Unimown Van  | ses U V              | Tinuson            | t                      | minous.                          | -am            | anda                              | Hu           | rst           | le section |
| 15. \   | NAS DECEASED EVER IN U SARMED FOR  | RCES? 16 SOCIAL      | SECURITY NO.       | INFORMANT              |                                  |                | Add                               | ress         |               |            |
| (1102,  | No   | 579 0                | 5 9234 Mr          | s. Myrt]               | e P. D                           | awson          | (Wife)                            |              |               |            |
|         | 18. CAUSE OF DEATH   Enfer only one co   | ouse per line for (c | o), (b), and (c) ] |                        |                                  |                |                                   |              | INTERVAL      | BETWEEN    |
|         | PART I. DEATH WAS CAUSED BY-   | Acute                | myocardial         | infarct                | ion                              |                |                                   |              | 6 da          | D DEATH    |
|         | DUE TO   |                      |                    |                        |                                  |                |                                   |              |               |            |
|         | Conditions, if any, which )  | , Arteri             | osclerotic         | heart o                | lisease                          |                |                                   |              | Appro         | ож 5 yr:   |
|         | gave rise to immediate DUE TO  | )                    |                    |                        |                                  |                |                                   |              |               |            |
| ш       | Information last   | c)                   |                    |                        |                                  |                |                                   |              |               |            |
| Z       | PART II OTHER SIGNIFICANT CON  | IDITIONS CONTRIB     | BUTING TO DEATH BU | NOT RELATED            | TO THE TERMIN                    | NAL DISEASE    | COND TION G                       | EN IN PART   | 1(a) 19. WA   | AS AUTOPSY |
| S.      | No   | one                  |                    |                        |                                  |                |                                   |              |               | No 🖫       |
|         | 200. ACCIDENT WAS UNDERLYING   20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |                      |                    |                        |                                  |                |                                   |              |               |            |
| MEDICAL | 20c. TIME OF INJURY Month, Doy, Ye<br>Haur a.m.  | White N              | of while fo        | ACE OF INJURY          | (Hame, farm,<br>ice bldg., etc.) | 20f. (City o   | or town)                          | (Co          | unty)         | (Stole)    |
| 1 7     | p. m   |                      | work               |                        | ) F                              | T7             | / 0                               |              |               |            |
| 1 1     | 21. I certify that I attended the  | deceased fra         | m 29 June          | , 19.00                | 2, to 2                          | Jura           | 1960                              | that I last  | saw the       | deceased   |
|         | alive an 5 July  | , 19 60              | , and that deat    | n accurred o           |                                  |                |                                   |              |               |            |
|         | ACTUAL MOLANIA   | $1 \cap 0$           | }                  |                        | ^                                | DDRESS (Stre   | et, city or tawn,                 | stote)       |               | ATE SIGNED |
|         | SIGNATURE / COMMAND  | X                    | anco               | M.D                    |                                  |                |                                   |              | 5_Ju          | ly 1960    |
|         | PHYSICIAN'S HENRY N. CLA   | MAN, Capt            | MC,U.S.A           | rmy Hosp               | ital,F                           | t Geo          | G. Meade                          | , Md.        |               |            |
| 220.    | BURIAL, CREMATION, 22b. DATE THERECONSTRUCTION 7/9/60  | " -                  | NAME OF CEMETERY O |                        |                                  |                | ON (City, town,                   | ,,           | (S            | itote)     |
| 23. F   | UNERAL DIRECTOR'S SIGNATURE  | A                    | DDRESS             | He cerla               | 24g, REC'D                       | REGISTR        | lgate, I                          | STRAR'S SIGN | NATURE        |            |
| [0]     | Irich Funeral Home   | 4210 Bela            | air Road.          |                        | DATE                             | MT. 8          | 60                                | William &    |               |            |
|         |  |                      |                    |                        | PAIL                             |                |                                   |              |               |            |



FOR STATE HUMLTH DEPT please execute the certificate, writing the word "pending" in pencil in Item 18. Give Peges 1, 2, and 3 to the funeral director. Page 4 should be executed the certificate, writing the word "pending" in pencil in Item 18. Give Peges 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with for. PM3. Page 5 may be retained for your files.

IO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file, pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any even. Within 72 hours after death.

VS. A15ME 5M 7/59 MARYLAND STATE DEPARTMENT OF HEALTH

Division of Satisfical Research and Records, 301 W. Preston Street, Baltimore 1, Maryland

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07587

| • i | PLACE OF DEATH   | 2. USUAL RESIDENCE (Where decessed lived, if institution: Residence before admission)  |
|-----|--|--|
| 4   |  | a. STATE b. COUNTY SAMO SAME   |
|     | Anne Arunde L  b. CTY OR TOWN (if outs de corporete imits,   c. LENGTH OF STAY IN 16   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)   |
| AF  | write RURAL and give nearest town)   | V.   |
| 4   | Severna Park P.O . 15 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)   | SET ,C   |
|     | at their at the transfer of transfer of the second section.  | ON A FARM?   |
|     | Carriton Hanor   | I Same   YES   NO 12   |
| 3   | NAME OF First Middle   | Lest 4 DATE Month Dey Year   |
|     | (Ive or print)   | DEATH July 29 1960 19  |
|     | Dorothy L. Dunbar  6. COLOR OR RACE   7. MARRIED   NEVER MARRIED     8   | , DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HKS.  |
|     | WIDOWED TO DIVORCED  | lest birthday) Months Deys Hours Min.  |
| Ι,  |  | Y 11 BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY?  |
|     | ione during most of working life, even if retired)   | I DIKE LACE (SING OF ISING) THE STREET OF WINNIES OF INTERIOR  |
|     | betired housevife   HOME   | Chillecothe, Chio. USA   |
| Ĩ   | netired housewife  | 14. MOTHER'S MAIDEN NAME   |
|     |  | T 2 3 - D 2 -1-2   |
|     | JOHN LOIN<br>5. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. 17.  | Lida Bickam Address  |
| - 1 | Yes, no, or unkown) (If yes give were rdetes of service)   |  |
|     | No Nono Nr   | Philipp Franklin (son)   |
|     | 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]  | INTERVAL BETWEEN ONSET AND DEATH   |
|     | PART I. DEATH WAS CAUSED BY: Coronary Occlusion  | succen   |
|     |  |  |
|     | DUE TO   |  |
|     | Conditions, if any, which (b)  |  |
|     | gave rise to immediate cause   |  |
|     | (e), stefing the underlying cause lest.  |  |
| ٠,  |  | T RELATED TO THE TERMINAL DISEASE COND.TION GIVEN IN PART 1(6) 19. WAS AUTOPSY   |
| 3   |  | PERFORMED?   |
|     |  | YES NO X   |
|     | 206. EXTERNAL CAUSE WAS 206. DESCRIBE HOW INJURY OCCURED. (E   | nier nature of injury in Part I or Part I of Itam 18.)   |
|     |  |  |
| 1   | 20c. T.ME OF INJURY Month, Day, Year   20d. INJURY OCCURRED ' 20e. PLA   | CE OF INJURY (Home, farm, 20f. (City or town) (County) (State)   |
| 1   | Hour a.m. While Not While let work   | ory, street, office bldg., etc.)   |
| - 1 |  | Id an Autopsy , Inspection A, Inquiry A, and in my opinion   |
|     | 21. I certify that I took charge of the remains described above, he  |  |
|     | death resulted from. Natural causes [X_], Accident [, Suic   | ide, Homicide Undetermined manner  |
|     | 1 1 000 1  | CHIEF MEDICAL EXAMINER   |
|     | ACTUAL PLUSTED HIT ALLINE  | ASSISTANT MEDICAL EXAMINER DATE SIGNED   |
| 1   | SIGNATURE STEELE TO THE STEELE STEELE SIGNATURE STEELE STE | DEPUTY MEDICAL EXAMINER FOR 7/30/60  |
|     | EXAMINER'S   | the state of the s |
| 2   | NAME (Type) Gustave H. Faubert 1 D. 20. BURIAL, CREMATION, 225. DATE HEREOF 226. AAME OF CEMETERY OF   | Address (Street, city, town, or county)  R CREMATORY 22d, ACCATION (City, town, or country) (Stety)  |
|     | REMOVAL (Specify)  | 90+1 (b, 1 7 9/2   |
|     | Junie Ung 3-1960 Urlegelle   | ni alional Irlington Va  |
|     | FUNERAL DIRECTOR STATE ADDRESS   | 240 REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE  |
|     | John m. Layer was America  | DATE AUG 4 '60 Carthur S. Flours   |
| 1-  | 4  | 1 1/1  |



240. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

Chilhun & Through

TO HOSPIAL POSTAL OF MACHERAL D

23 FUNERAL DIRECTOR'S SIGNATURE

the bearing the series

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The holder is the whole who and the

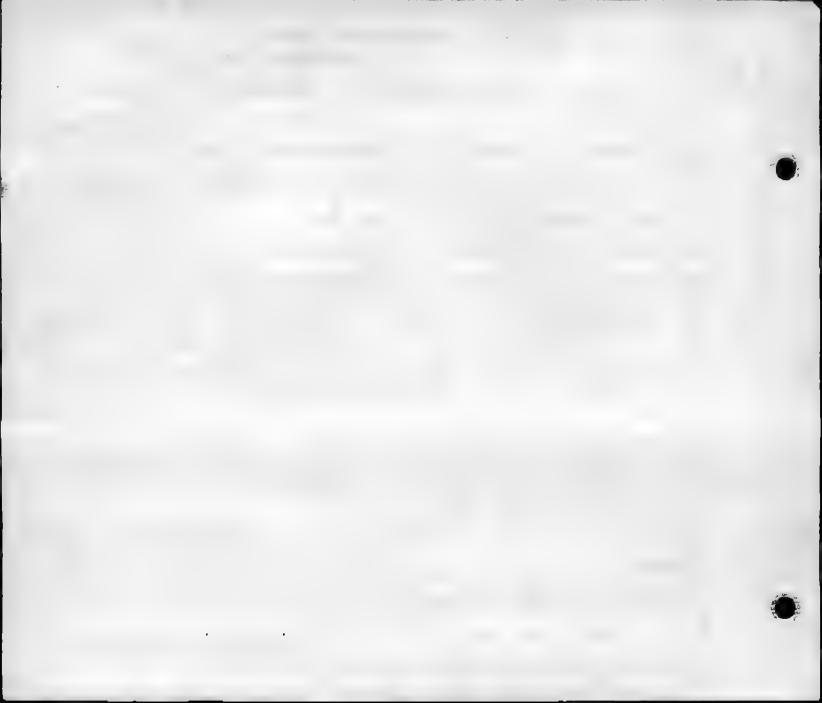
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07588

| L             | • 000   | CERTIFICA                      | AIL OI DEAIII   | Reg  | Dist. No.  |
|---------------|---|--------------------------------|---|--|--|
| 1,            | PLACE OF DEATH O. COUNTY A. A. Co-  | MARYLAND                       | 2. USUAL RESIDENCE (Where o. STATE                            | e deceased fived. If institutions Res<br>b. COUNTY | idence before admission)                           |
|               | b. CITY OR TOWN (If outside corporate limits, write<br>RURAL and give nearest town)                           | c. LENGTH OF STAY IN 16        | H3.   | side corporole limits, write RURAL                 | ond give nearest town)                             |
|               | d. NAME OF HOSPITAL (If not in hospital give street OR INSTITUTION)   | ADENA MA                       | d STREET ADDRESS  | E. LOBRAINE  | . 15 RESIDENCE<br>ON A FARM?<br>YES NO             |
| 3.            | NAME OF DECEASED (Type or print) HOM/3 S  | Middle  MITH AND               | ich FERCION   | DATE Month   | Doy Yeor   |
| 5.            | SEX / 6. COLOR OR RACE 7 MARR WIDOWS  |                                | 8. date of birth<br>1882                                      | 9. AGE (In years IF UK fost bigthday) - Mont       | DER TYEAR IF UNDER 24 HRS Thi Doys Hours Min       |
| 2             | o. USUAL OCCUPATION (Give kind of work done) 10b during most of working life, even if retired)  ELECRIPH OPER | KIND OF BUSINESS OR INDUS      | ED WESTE  | ENPORT MO  | CITIZEN OF WHAT COUNTRY                            |
|               | FATHER'S NAME   | 107                            | 14. MOTHER'S MAIDEN NAI                                       | MEGUIBE  |  |
|               | es, no or unhapma) (If yes, give war or dates of service)   | f. s                           | STHOS FER   | Crot VR  |  |
|               | 1B. CAUSE OF DEATH [Enter only one couse per lin PART! DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)               | te for (o), (b), and (c), ]    | 20 12 44/16   | in contract  | INTERVAL BETWEEN ONSET AND DEATH                   |
|               | Conditions, if ony, which gove rise to immediate  | Enior le ce Te                 | i. 6. 11/10 .   | aredar Ann   | 11 2 years   |
| 7             | couse (o), sloting the under-   | Willey us                      | Lung ile 36   |  | si jedi.   |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS C   | 720.11                         | LA -  |  | PART 1(o) 19, WAS AUTOPSY PERFORMED? YES NO        |
|               |   |                                | D. (Enter noture of injury in Por                             |  |  |
| MEDICAL       | 20c. TIME OF INJURY Month, Doy, Year 20d If Hour o m. 19 While of world                                       | Not while for                  | ACE OF INJURY (Home, form, clory, street, office bldg., etc.) | 20f. (City or town)                                | (County) (State)                                   |
|               | 21. I certify that I attended the decease alive on 126 fee 20, 19.  | ed from Yeller, and that death | 176-5-10-F  | M, from the causes and a                           | t I last saw the deceased in the date stated abave |
|               | ACTUAL SIGNATURE - Perfect file to  | wee inters                     | M.D. 2201 226 222   | DORESS (Street, city or town, stote)               | DATE SIGNES  |
|               | PHYSICIAN'S R. Ma. Pich   | augnite;                       |   |  | 1xil / 1   |
| 777           | REMOVAL (Specify)  7/25/60  | Gardens of                     | Faith Cem.  | 2d. LOCATION (City, town, or cour Balto.           | oty) (Stote)                                       |
| 23            | FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                        | 24o. REC'D  | BY REGISTRAR 245, REGISTRAR                        | S SIGNATURE  |
| '             | ALEDESELD & SOL-Green   | Jount Ave &                    | 22nd DATE JUL   | 2.00   |  |

24 haurs offer death. Page 4 in by the funeral director, and 2 shauld be, filed with TO MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificale be executed within may elatined by the hospital are attending physician.

TO FULLAL DIRECTOR: After this certificate has been signed by the attending physician and campeterly to page 3 shauld be detached far use as the burial-transit permit. Then please remove carbon pagers. Page the registrar prior to burial, cremation, or remayal, and in any event within 72 hours after death VS A15 (4) 15M 9/SS





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bellin

Sicia. attending phys

hospital After this

FUNERAL DIRECTOR:

detached

should

the has been signer burial-transit p physicion.

cremation,

Q.

the death

PLACE OF DEATH

p. COUNTY

b. COUNTY Anne Arundel b. CITY OR TOWN (If autside corporate limits, write c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) Annapolis d NAME OF HOSP TAL (If not in hospital, give street address) IS RESIDENCE OR INSTITUTION ON A FARM? Anne Arundel General Hospital YES NO TE NAME OF Manth Day Year DECEASED (Type or print) July 28 1960 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED TO B DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Manths Days Hours Male White DIVORCED | July 27, 1960 WIDOWED [ 20 YES 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S. Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Donald Richard Gormley Betty Jo Schwieterman 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address Hospital records 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND BEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I at Part II of stem 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY [Hame, farm, 20f (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Haur a.m. While Nat while at wark 🔲 at wark 🦷 p. m. 21 I certify that (1) (this hospital) attended the deceased from July 27, 1960, to July 28, 1960, that (1) 70%) last saw the deceased alive on July 28. 19 60, and that death occurred at \_\_\_\_ M, from the causes and an the date stated above 22a SIGNATURE 1:45 P.M. SIGNED MED. STAFF PHYS M D 22c PHYSICIAN'S 22d, ADDRESS Niel H. Sims Cathedral St., Annapolis, Md. 230. BURIAL CREMATION. DATE THEREOF NAME OF CEMETERY OR CREMATOR) 23d (OCATION (City, town or county) REMOVAL (Specify) 250 REC'D BY REG STRAR REGISTRAR'S SIGNATURE

0 VR A1S (4) 1SM 9/S9



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, if institution: Residence before edmission) y is necessary, I director. Page or your files. oard of Health, e. COUNTY **b.** COUNTY a. STATE Anne Arundel Maryland MARYLAND b. CITY OR TOWN (I outside corporele limits, E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete timits, waite RURAL end give nearest town) wr to RURAL and give neerest town) Baltimore Annapolis for Boar d. NAME OF HOSP TAL OR INSTITUTION (if not in hospital, give strent address) d. STREET ADDRESS funeral refained 4707 Wrenwood Street State Anne Arundel General Hospital 4. DATE DECEASED 3 to the (Type or print) JAMES GREEN DEATH July with 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED 8. DATE OF BIRTH AGE (In years ) IF UNDER 1 YEAR 5. SEX 2 with Page 5 and set 1 and 2 and 2 with 72 hours at last birthday) Months DIVORCED Dec. 11, 1929 Male WIDOWED 10e USUAL OCCUPATION (Give kind of work 105 KIND OF BUS NESS OR INDUSTRY 11. BIRTHPLACE (Stelle or foreign country) done during most of working life, even if retired) ve Pages 1 PM3, Pag Social Security Balto. Md.  ${ t Clerk}$ pages 1 13.) FATHER'S NAME 14 MOTHER'S MAIDEN NAME 8. Give Joshua Green Mary Green File form IS. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16, SOCIAL SECURITY NO | 17. INFORMANT Address (Yes, no, or unkown), (Ifyesgive werordetes of service) Korean Margaret B. Green 4707 Wrenwood Street Ave. 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c), Office along w burial-transit p PART I. DEATH WAS CAUSED BY: Hypertensive and Arteriosclerotic Heart Disease IMMEDIATE CAUSE (e) in pencil This certificate should be with Total Occlusion of Right Coronary Artery and ADDRESS. One Branch of Left Coronary Artery, and Old Conditions, if any, which "pending" Myocardial Infarction. Examiner's DLE TO (e), stetting the undarlying nsed PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), 19, WAS AUTOPSY 2 execute the certificate, writing the word Medical shomld 20e. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Pert I or Pert II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH Chief 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20c. TIME OF INJURY Month, Day, Year 20f. (Cily or fown) fectory, street, office bldg., etc.) Not While Hour a.m. at ■ prior forwarded to t 21. I certify that I took charge of the remains described above, held an Autopsy 🗶 Inspection agent, death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER TO ACTUAL ASSISTANT MEDICAL EXAMINER should be for FUNERAL 1 SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S Russell S. Fisher. M.D. NAME (Type) Address (Street, city, town, or county) 22c. NAME OF CEMETERY OR CREMATORY 22e, BURIAL, CREMATION, 22b. DATE THEREOF 22d, LOCATION (City, town, or country) REMOVAL (Specify) Burial Balto National Cemetery Balto. Md. 0 Q40 240. REC'D 8Y REGISTRAR | 245. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR

Halstead & March 928 E. North Ave.

. IS RESIDENCE

YES NO

19

12, CITIZEN OF WHAT COUNTRY?

INTERVAL SETWEEN ONSET AND DEATH

PERFORMED?

NO

(State)

and in my opinion

DATE SIGNED

(State)

7/5/60

USA

{County]

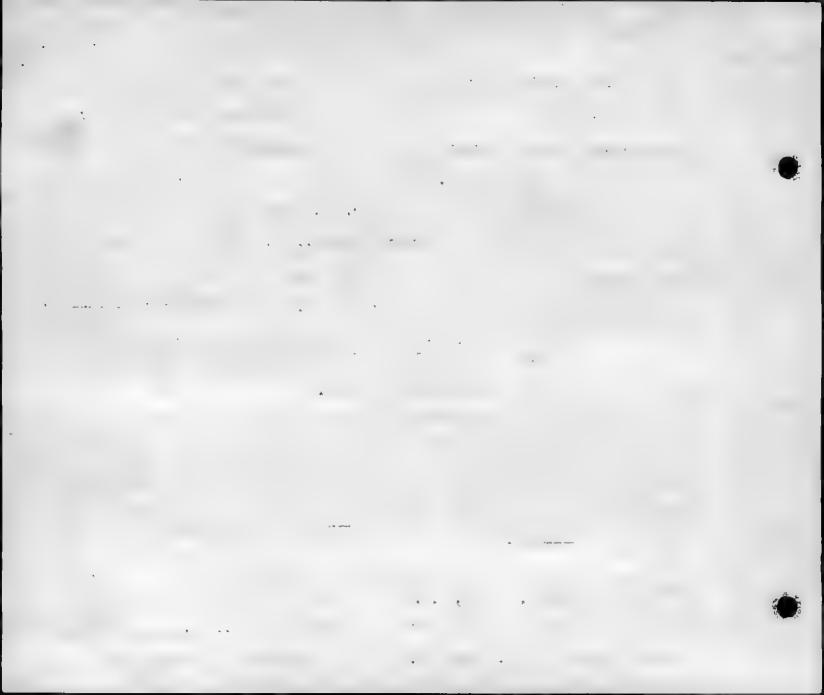
Circling S. Kraus

IF UNDER 24 HRS

ON A FARM?

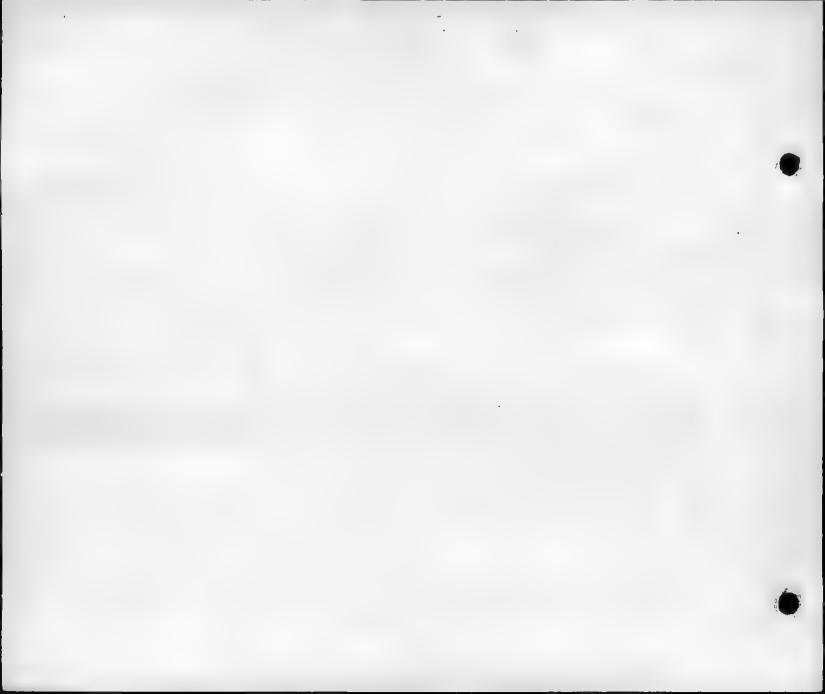
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VS. ATSME 5M 7/59



7634 **CERTIFICATE OF DEATH** Reg. Dist. No. 7593 director, filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY a. STATE b. COUNTY MARYLAND the funeral should be fi b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside aproporate limits brothe RURAL and give nearest town) RURAL and give nearest lown) d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. 15 RESIDENCE OR INSTITUTION YES NO NAME OF First 4. DATE Middle Month Day Yeor DECEASED Pages (Type or print) DEATH 196 9. AGE/In years lost birthdoy) 5 SEX 6 COLOR OR RACE 7. MARRIED A NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH Months Days WIDOWED [ DIVORCED [ 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) rban paperer death. 12 CITIZEN OF WHAT COUNTRY? aduring most of working life, even if retired puo 13 FAIHER'S NAME 14. MOTHER'S MAIDEN NAME 9 6 Elle with in 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address aftending CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY-IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** couse (o), stoling the underlying couse lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 19. WAS AUTOPSY PERFORMED? YES 🗍 NO 📆 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. While Not while of work of work 21. I certify that I attended the deceased fram. 1920, that I last saw the deceased alive on \_, and that death occurred at 🔼 \_ £ M, from the causes and on the date stated above. ADDRESS (Street, city or lown, state) DATE SIGNED ACTUAL SIGNATURE DETERMINATION OF NAME (Type) 22b. DATE THEREOF 220 BUR AL EREMAT ON, 22c. NAME OF/CEMETERY OR GREMATORY 22d LOCATION (City town, or county) (State) REMOVAT (Specify) 1021 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS A1S (4) women & though 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



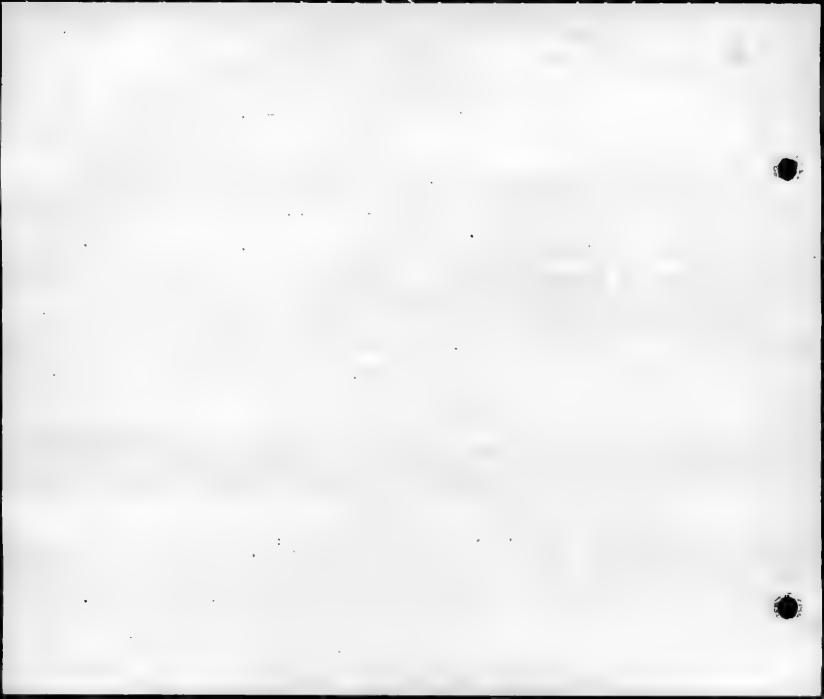
#### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CEPTIFICATE OF DEATH

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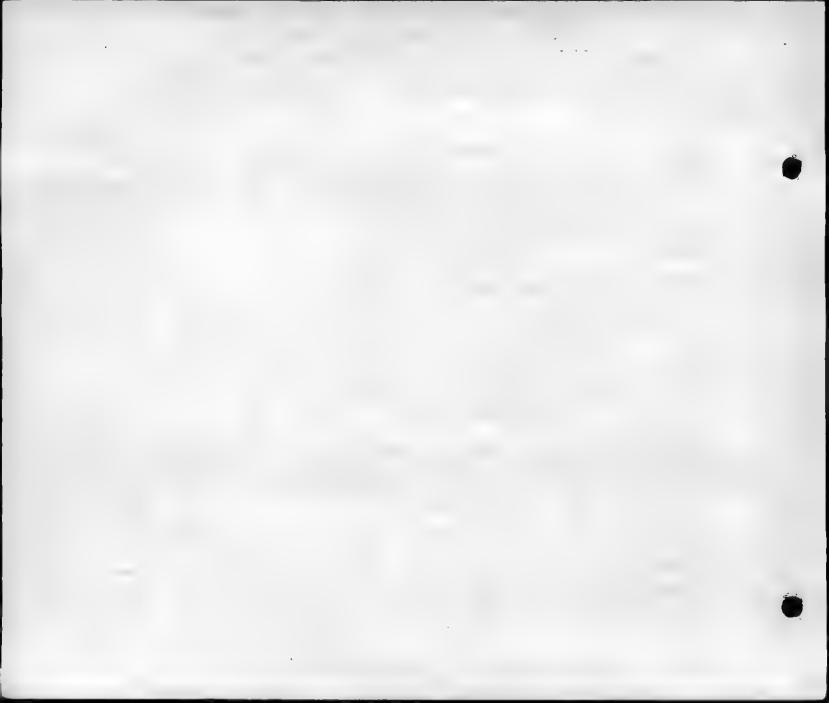
|               |                           | - "   |                      | CERTITIO               | AIL OI D              |                |                  |                      |                |              |                   |
|---------------|---------------------------|---|----------------------|------------------------|-----------------------|----------------|------------------|----------------------|----------------|--------------|-------------------|
| 1. P          | PLACE OF DEAT             | Н   |                      |                        | 2 USUAL RES           | IDENCE (Wh     | ere deceased l   | ived If institution: | Residence be   | fore admiss  | on)               |
|               |                           | Anne Arund  | el                   | MARYLAN                | סו                    | Maryl          | and              | b. COUNTY            | Anne Ai        | runde.       | L                 |
| t             |                           | VN (If outside corporate ive neorest town)              | amits, write c.      | LENGTH OF STAY IN      | c CITY OR             | TOWN (If o     | utside corporal  | le limits, write RUR | AL and give n  | searest town | )                 |
|               | Anna                      | polis   |                      | 2 days                 | F                     | RURAL .        | - Gales          | ville,               |                |              |                   |
|               | OR INSTITUTI              | OSPITAL (If not in hospite<br>ION<br>Idel General       |                      |                        | d. STREET             | ADDRESS        |                  |                      |                |              | FARM?             |
| 3. N          | NAME OF                   |   | First                | Middle                 | Lo                    | al .           | 4. DATE          | Month                |                |              | Year              |
|               | Type or print)            | Arth  |                      | Lee                    | HARDI                 |                | OF<br>DEATH      | July                 |                | n al         | 1960              |
| 5 5           | EX                        | 6 COLOR OR RA   | CE 7. MARRIED        | NEVER MARRIED [        | B. DATE OF BIRT       | Н              | 9.               |                      | Months Days    |              | R 24 HRS<br>Min.  |
| M             | Male                      | White   | WIDOWED              | DIVORCED [             | l August              | 9, 19          | 17               | 42 yrs.              | nonins buys    | Hours        | mun,              |
| 10a           |                           | PATION (Give kind of wi<br>working life, even if ret    |                      | ID OF BUSINESS OR IN   | DUSTRY 11 BIRTHE      | LACE (State    | ar foreign cour  | ntry)                | 12 CITIZEN     |              | OUNTRY?           |
| F             | LANT                      | FOREMAN   | Bol                  | Hed hids               | Ma                    | rylan          | d, 1731          | esuille              | U              | .S.          |                   |
| 13.           | FATHER'S NAMI             | E a l   | 21 1                 | 1.                     | 14. MOTHER            | MAIDEN N       | NAME             | ~ 4/                 | 1 4            | et           | 1                 |
| Z             | HOMA                      | S ALVIN 1   | NYdCS!               | × 9                    | Chri                  | ster           | re l             | U./DE                | della          | p Ja         | lesu              |
|               | WAS DECEASED              | DEVER IN J. S. ARMED."<br>[19 yes, give wor or doler    | of service)          |                        | 7 INFORMANT           | 14             | 1 /              | Address              | 1              | , ,          |                   |
|               | 105                       | wwi   | 22                   | 0 26-4950              | KUTU L                | Ifd'r          | 1554             | Md/e                 | SUILL          | a My         | d.                |
|               |                           | DEATH [Enter only on                                    |                      | ar (0), (b), ond (c).] |                       |                |                  |                      |                | NTERVAL BE   |                   |
|               | PART I.                   | MMEDIATE CAUSED I                                       |                      | en, carcin             | omatosis              |                |                  |                      |                |              |                   |
|               | -                         | DUE *   | TO                   |                        |                       |                |                  |                      |                |              |                   |
|               |                           | if any, which   | (b) C 57             | cinoma of              | pancreas              |                |                  |                      |                | 7 mos        | 5.                |
|               |                           | lo immediate (<br>ting the <u>under-</u> DUS            | TO                   | ,                      |                       |                |                  |                      |                |              |                   |
|               | lying couse I             |   | (c)                  |                        |                       |                |                  |                      |                |              |                   |
| CERTIFICATION | Part H.                   | OTHER SIGNIFICANT O                                     | ONDITIONS <u>COM</u> | NTRIBUTING TO DEATH    | BUT NOT RELATED T     | O THE TERMI    | NAL DISEASE (    | CONDITION GIVEN      | I IN PART 1(0) | PERFC        | AJTOPSY<br>PRMED? |
| CERTIFIC      | OR CONTRIBU               | T WAS UNDERLYING TING CAUSE OF DEADTIFY MEDICAL EXAMINI | ATH                  | BE HOW INJURY OCCU     | IRRED (Enter nature   | of injury in I | Port I ar Part I | Fof item 18.)        |                |              |                   |
|               | 20c. TIME OF II           | NJURY Month, Day,                                       | Year 20d, INJU       | RY OCCURRED 20e        | PLACE OF INJURY       |                |                  | r fown)              | (Caunt         | y)           | (Stote)           |
| MEDICAL       |                           | m   | While of work        | Not while at work      | factory, street, affi | e blolg, etc   | -)               |                      |                |              |                   |
| 2             |                           | that (1) (this hasp                                     | -                    |                        | January               | 10             | 60 to J1:        | ly 18,               | 1060           | that (1) (   | VOCK! ove         |
|               |                           | ceased alive an _                                       |                      |                        |                       |                |                  | - +                  |                |              | ,                 |
|               | 220. SIGNATUI             | RE .  | and the second       | E 1003841 GHG III      | or deally decorre     | 8:50           |                  | ic cooses and        | dil lile do    |              | b. DATE           |
|               |                           | 7.69  | TONO WE              | 6 ruis                 | M.D PHYS.             | IG _ MI        | RECTOR [         | STAFF<br>PHYS.       |                | 7/19         | /SIGNED           |
|               | 22c PHYS CIAI<br>NAME (Ty |   |                      |                        | 27d. ADDI             | RESS           |                  |                      |                |              |                   |
|               | TANNE (1)                 | Samuel E  | Borssuck             |                        | Amos                  | Garre          | tt Blvd          | l., Annap            | olis.          | Md.          |                   |
| 23a           | BUR AL CREM               | IAT ON 236. DATE THE                                    |                      | WANTE OF CEMETER       |                       |                | 1                | ON (City, town, or   |                | Show         | 10)               |
| 24            | EL NERAL DIREC            | TOR'S SUSNATURE   | 1 0                  | ADDRESS DA             | 30.1                  | 25a REC'       | D BY REGISTRA    | AR 25b REGISTI       | RAR'S SIGNAT   | TURE         | 1                 |
| 0.            | Bernet                    | clo. Harch  | este .               | elesville              | o vescol.             | DATE HI        | 2 6 '60          | 6                    |                |              | ,                 |

urs after death. Page 4 filled in by the funeral director, ges I and 2 should be filed with 

VR A1S (4) 1SM 9/59



| 1  | 70   | 1 tem_20_Film CMARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |
|--|--|--|
| W 2.E  | 7  | 7594 CERTIFICATE OF DEATH Reg. Dist. 10.7595   |
| directo  | *  | 1. PLACE OF DEATH O. COUNTY MARYLAND  2. USUAL PESIDENCE (Where deceased, lived. If institutions Residence before admission) b. COUNTY B |
| r death<br>funeral   | M  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  RURAL and give nearest town  FINE POILS  |
| ors offe<br>by the   | XI.  | A STREET ADDRESS  ON A FARM?  ON A FARM?  YES ON NOTION OF THOSPITAL (If you prinospital, give street address)  ON A FARM?  YES NOTION OF THOSPITAL (If you prinospital, give street address)  ON A FARM?  YES NOTION OF THOSPITAL (If you prinospital, give street address)  ON A FARM?  YES NOTION OF THOSPITAL (If you prinospital, give street address)  |
| in 24 ho   | ( )  | 3. NAME OF DECEASED (Type or print) Mattle Widdle Hardesty 4. DATE OF DEATH JULY 9 1960  |
| pletely<br>preservers. Pog   |  | Temale White widowed Divorced Marked 8, 1883 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR)  |
| and com<br>on pape<br>death.                                       |  | 100 USUAL DCCUPATION (Give kind of work done let CIND OF BUSINESS OF INDUSTRY IT BIRTHPLACE Stole or foreign country)  School Reacher Ubic School  12. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  13. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  14. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  15. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  16. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  17. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  18. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  18. CITIZEN OF WHAT COUNT  SCHOOL REACHER UBIC SCHOOL  SCH |
| cate be<br>sicion o<br>ve carb                                     |  | 13 FATHER'S MANE E. Hardesty Martha Chaney   |
| h certifi  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANY ARE L. Hardes Address (1911 year, give wor or doring of service)  |
| he deat<br>attend<br>en plea<br>nt within                          | A A STATE OF THE S | 18. CAUSE OF DEATH [Enter only one course per line for (a), (b), and (c).]  PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  PART 2. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (b)   |
| s that the distribution of the | i.   | Conditions, if bny, which) (b) Franctine puts.   |
| require<br>on.<br>n signer<br>sit per                              |  | gove rise to immediate couse (a), stating the under-lying couse last.  DUE TO  (c)   |
| he faw<br>physici<br>has bee<br>rial-trar<br>naval, c              | ^  | Part 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO FOR CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH USE THER. NOT FY MEDICAL EXAMINER! Fell off of chair at home  |
| tending<br>ificate<br>ificate<br>the bu                            |  |  |
| PHYSIC<br>hat ar all<br>this cert<br>in use as                     |  | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURED Hour Xacac II p.m. 6-10 150 of work of work at work at the second of work at the second of the seco |
| NDING<br>e haspife<br>t: Affer<br>ached fo                         | 1  | 21. I certify that I ottended the deceased from 1600, 1960, to 416, 1960, that I last saw the decease alive on 1600, 1960, and that death occurred at 600 M, from the causes and on the date stated about  |
| RECTOR The detection to be   | /  | ACTUAL SIGNATURE Thill H. Wash M.D. Littlem, M.D. 7-11.  |
| taine<br>XAL Di<br>shauld  |  | PHYSICIAN'S<br>NAME (Type)   |
| may<br>Dege 3  | c.F  | 220. BURIAL CREMATION. 226 DATE THEREOF 220 NAME OF CEMETERY OR CREMATORY 220 LOCATION (City, town, or county) PSMOVAL (Specify) JULY 11,1960 St. James Cemetery Taceys MG.  |
| VS A15 (4)<br>15M 9/55   |  | 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS DATE SUB 1 2 '60 Cirtur & France   |



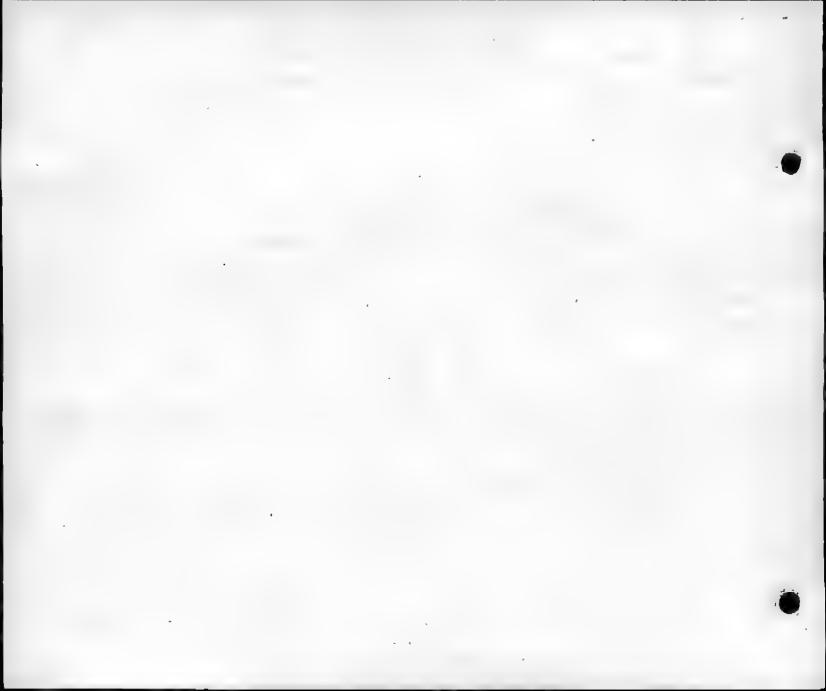
VS A15 (4) 15M 9/58 Novs

#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7635 CERTIFICATE OF DEATH

Reg. Dist 0.7596

|               |  |   | 1717         | ,,                         |                     |                  | <b>"</b>            | R                | eg. Dist[]   | 16. 00     | 0                   |
|---------------|--|---|--------------|----------------------------|---------------------|------------------|---------------------|------------------|--------------|------------|---------------------|
|               | ACE OF DEATH   |   |              |                            | 2. USUAL RI         | ESIDENCE (Who    | are deceased lived  |                  | Residence be | efore admi | ission)             |
| J             | Ar   | ne Arundel                                      |              | MARYLAND                   | a. STATE            | Maryla           | nd                  | . COUNTY A       | nne Ar       | runde      | 1                   |
|               | CITY OR TOWN (#  | f outside corporate limi                        | its, write   | c LENGTH OF STAY IN TE     | c. CITY O           | R TOWN (If or    | stade corporate lin | nits, write RURA | L ond give i | nearest to | wn)                 |
|               |  | e G. Meade                                      |              |                            | X                   | Fort G           | eorge G.            | Meade            |              |            |                     |
| d.            | NAME OF HOSPIT   | AL (If not in hospital, g                       |              |                            | d. STREE            | ADDRESS          |                     |                  |              |            | ESIDENCE<br>A FARM? |
|               | OK HASHITOHOU  | U. S. Army                                      | Hos          | pital                      |                     | 7006-0           | Antelak             | Street           |              |            |                     |
|               | AME OF   | Fir   | st           | Middle                     |                     | Last             | 4. DATE             | Month            |              | Day        | Yeor                |
|               | CEASED<br>ype or print)  | AL  | BERT         | N.                         | HARP                | ER               | OF<br>DEATH         | July             |              | 13         | 19 60               |
| S SE          | X  | 6 COLOR OR RACE                                 | 7. MARR      | RIED NEVER MARRIED         | 8. DATE OF BI       | RTH              | 9. AG               |                  | UNDER 1 YE   |            |                     |
|               | MALE   | Negro   | WIDOW        | ED DIVORCED                | 13 Ju               | ly 1960          |                     | yes.             | onths Day    | s Haurs    | 38                  |
| 10a. (        | USUAL OCCUPATIO  | ON (Give kind of work ing life, even if retired | done 10b.    | KIND OF BUSINESS OR INC    | USTRY 11. BIRTH     | PLACE (Stole of  | or foreign country) |                  | 12. CITIZEN  | OF WHAT    | COUNTRY?            |
|               | N/I  | A   | <u></u>      | N/A                        |                     | Maryla           | ınd                 |                  | U.3          | S.A.       |                     |
| 13. FA        | ATHER'S NAME   |   |              |                            |                     | R'S MAIDEN N     |                     |                  |              |            |                     |
|               | Emanuel H  | Tarper  |              |                            | E                   | velyn I          | . Smith             |                  |              |            |                     |
|               | AS DECEASED EVE  | R IN U. S. ARMED FOR                            | CES? 16.     | SOCIAL SECURITY NO.        | INFORMANT           |                  |                     | Address          |              |            |                     |
|               | N/A  | N/A   |              | N/A                        | Mr. Eman            | uel Har          | per,7006            | C Ante           | lak Si       | s, Ft      | Mead                |
| 11            |  | -   |              | ne for (o), (b), and (c).] |                     |                  |                     |                  |              | NTERVAL E  |                     |
| Ш             | PART I DEA   | TH WAS CAUSED BY: IMMEDIATE CAUSE (a            | E:           | xtreme premat              | urity               |                  |                     |                  |              | INDEL MIN  | DEATH               |
|               | フラ   | DUE TO  |              |                            |                     |                  |                     |                  |              | _          |                     |
|               | Conditions, if a   |   | )(           |                            |                     |                  |                     |                  |              |            |                     |
|               | gave rise to it<br>couse (a), stating t  | nmediate (                                      | •            |                            |                     |                  |                     |                  |              |            |                     |
|               | lying cause last.  | (c  | )            |                            |                     |                  |                     |                  |              |            |                     |
| NO.           | PART II OTH  | ER SIGNIFICANT CON                              | D TIONS O    | CONTRIBUTING TO DEATH B    | JT NOT RELATED      | TO THE TERMIN    | NAL DISEASE CON     | DITION GIVEN     | IN PART 1(o) | 19. WAS    | S AUTOPSY<br>ORMED? |
| S.            |  |   |              |                            |                     |                  |                     |                  |              |            | □ 0N □              |
| CERTIFICATION | 20a ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.) |   |              |                            |                     |                  |                     |                  |              |            |                     |
| WEDICAL       |  | Y Month, Day Ye                                 | ar 20d. II   | NJURY OCCURRED 20e         | PLACE OF INJUR      | Y (Home, form,   | 20f. (City or tov   | vn)              | (Cauni       | ly)        | (State)             |
| WED           | Hour a.m.  | 19  | While of wor | Not while                  | factory, street, of | fice bldg., efc. |                     |                  |              |            |                     |
| 2             | 1 Certify th   | at Lattended the                                | deceas       | ed fram 13 Jul             | v 196               | 0 to 1           | 3 July              | , 1960,the       | at I lost e  | aw tha     | deceared            |
|               |  | L3 July   | 19           |                            |                     |                  |                     |                  |              |            |                     |
|               |  |   |              |                            |                     |                  | ADDRESS (Street, c  |                  |              |            | ATE SIGNED          |
| S             | CTUAL WIGNATURE W  | elleur  | 7/-          | miller                     | M.D.                |                  |                     |                  |              | 13 Ju      | ly 60               |
| PN            | HYSICIAN'S W.  | ILBUR H. MJ                                     | ILLER        | ,JR.,CAPT,MC               | U.S.A               | rmy Hos          | pital,Ft            | Geo G.           | Meade        | e, Md      |                     |
| 220. 8        | BURIAL, CREMATIO   | N, 226. DATE THEREC                             | )F           | 22c. NAME OF CEMETERY      |                     |                  | 22d. LOCATION (     |                  |              |            | ota)                |
| Cr            | emation  | 13 Jul 6  | 0            | Laboratory, U.             |                     | Hospita          | 1,Ft Geo            | G Mead           | e, Mary      | Land       |                     |
| 23. FL        | INERAL DIRECTOR  |   | 3 002 0      | ADDRESS B.M.               | ELLIS               | 24a. REC'C       | BY REGISTRAR        | 24b. REGISTR/    |              |            |                     |
|               | 11/2 656   | Capt Capt                                       | ·,MSC        | , USAH, FGGM               |                     | DATE             | 1 8 '60             | athur            | J. S. Hra    | 0.4        |                     |
|               |  |   |              |                            |                     |                  |                     |                  |              |            |                     |



TO HOS ALOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Its after death. Page 4 may the hospital or attending physician.

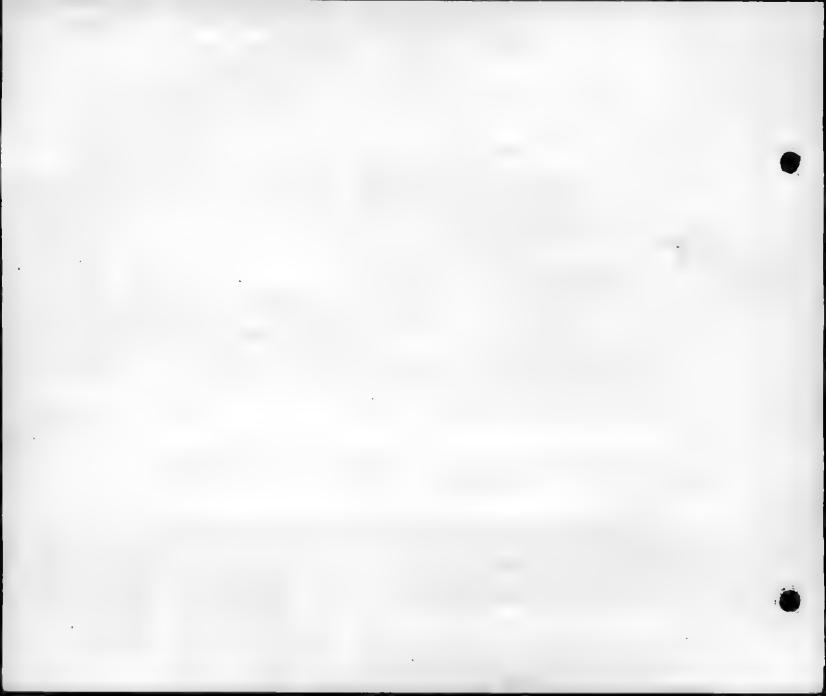
TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and campletely filled in by the funeral director, page 3 shmuld be detached for use as the burial-transit permit. Then please semage carbon papers. Pages 1 and 2 shauld be filed with hin 72 hours after death the State Board of Health priar to buriol, cremotion, or removal, and in any/event, will

VR A15 (4) 15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07598

|   | 1. PLACE OF DEATH O. COUNTY  MARYLAND  2 USUAL RISIDENCE (Where difference lived. If institution Residence before admission) Q. STATE (I.E. A. C. COUNTY)  |
|---|--|
| ) | many many many many many many many many  |
|   | C. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
|   | d. NAME OF HOSPITAL (If not in haspital, give street address)  OR INSTITUTION  d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES  YES  |
|   | 3. NAME OF DECEASED (Type or print) Edward Have Pearly Death 7 8 1960  |
|   | S SEX 6 COLOR OF RECE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years light birthday) Months Days Hours Min  |
| , | 100 VSJA. OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY TO BIRTHPLACE (State or foreign country)  12. CITIZER OF VYHAT COUNTRY?  13 FATHER'S NAME  14. MOTHER'S MAIDEN NAME   |
|   | Joseph Harrey Rebecca Deters   |
| ) | 15. WAS DECEASED EVER IN U. S. AFMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT  (Ves. no. or unknown) (If yes give well or dollar of service) 220-24-1019 Elenobeth Harveyn/est/RuseMd.   |
|   | IB. CAUSE OF DEATH [Enter only ane cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under-   |
| 7 | PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BJT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON G VEN IN PART 1 (a) 19. WAS AUTOPSY PERFORMED?   YES   NO DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 1B.)  |
|   |  |
|   | 20c TIME OF NJURY Month, Doy, Year 20d INJURY OCCURRED Haur a. m. 19 While Not while of wark o |
|   | 21 I certify that (I) (this hasbital) attended the deceased fram 1900  |
|   | 224 SGNATURE  M.D PHYS  MED DIRECTOR STAFF  PHYS DIRECTOR STAFF  226 DATE  S GNED  227 ADDRES  228 ADDRES  |
|   | MAME (Type) KL, KICHARDSOH 10-10LAYSTHY POHASLID, 198  |
|   | 230 BURIAL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23c. LOCATION (City Jown, or county)  SEMOVAL (Specify)  4 OUR OF CEMETERY OR CREMATORY  23c. NAME OF |
|   | Milliam Reesett and Mate JUL 13'60 aims & thomas   |



| 1             | PLACE OF DEATH<br>o COUNTY                                     | Anne Arunde   | 1 M  | ARYLAND   | 2 USUAL RESIDE  | ENCE (Where               | _ b                  | If institution                |                | efore admissi             |                  |
|---------------|--|---|--|---|---|---------------------------|----------------------|-------------------------------|----------------|---------------------------|------------------|
|               | b CITY OR TOWN (If of<br>RURA, and give near<br>Anna pol       |   | te c LENGTH OF S   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  Annapolis |                           |                      |                               |                |                           |                  |
| A             | OR INSTITUT ON   | (If not in hospital, give st<br>General, Hos                |  | d. STREET ADDRESS  8 Kirbys Lane  1 S RESIDENC ON A FARM YES [] NO. |   |                           |                      |                               |                |                           |                  |
|               | NAME OF<br>DECEASED<br>(Type or print)                         | First   | Мн   | ddle  | HENSON  |                           | DATE<br>OF<br>DEATH  | July                          |                |                           | 19 60            |
| T             | Female   | **  | AARRIED NEVER MA   | RRIFO B   | July 30   |                           | lost                 | (In years<br>birthdoy)<br>yrs | Months Doy     |                           | 7 24 HRS         |
| 100           | during most of working   | (Give kind of work done<br>g life, even if retired)         | 106 KIND OF BUSINES  | S OR INDUST   |   | CE (Stote or !<br>!arylar |                      |                               |                | J.S.                      | OUNTRY           |
| 13            | FATHER'S NAME  | 4 B. T  | Henry  | n   | 14 MOTHER'S   | LOWN.                     | ma                   | kell                          |                |                           |                  |
|               | WAS DECEASED EVER  | IN U. S. ARMED FORCES?<br>yes, give war or dates of service | 16. SOCIAL SECURITY  | NO 17 INF   | PRMANT  | /                         | Heno                 | Addre                         | Ain            | refit                     | 4                |
|               | Conditions, if ony gove fise to im cause (o), stoting th       | mediote (   |  |   | -time F   | re tali                   | » - De               | inem 14                       |                | INTERVAL BE<br>DINSET AND | DEATH            |
| CERTIFICATION | PART I OTHE  | ) (c)<br>R SIGNIFICANT CONDIT C                             | INS CONTRIBUTING TO  | DEATH BUT N   | OT RELATED TO   | THE TERMINA               | L DISEASE CON        | dition g ve                   | EN IN PART 1(a | PERFO                     | AUTOPSY<br>RMED? |
|               | 200. ACCIDENT WAS<br>OR CONTRIBUTING E<br>(IF EITHER, NOTIFY M | UNDERLYING (1) 206. CAUSE OF DEATH EDICAL EXAMINER)         | DESCRIBE HOW INJUR   | Y OCCURRED  | (Enter nature of  | injury in Port            | I or Port II of i    | tem 18.)                      |                |                           |                  |
| MEDICAL       | 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.                     | - W   | Od. INJURY OCCURRED  (hile Not while work of work to the work to t |   | E OF INJURY (H  |                           | 20f. (City or tow    | rn)                           | (Caur          | ity)                      | (State           |
|               |  | (1) (this hospital) at d alive an July                      |  |   | ATTENDING PHYS. 22d ADDRES  | 11:00<br>MED.<br>DIREC    | fram the c           | ouses and                     |                | ate stated                |                  |
| 230           | REMOVAE (Sandy)  | , 236 DATE THEREOF, Aug 2/ fo                               | 1 Bru  | CEMETERY OR   | CREMATORY   | 23                        | d LOCATION !         | City, town, o                 | r county)      | AA (Slot                  | nef              |
| 24            | FUNERAL DIRECTOR'S   | SIGNATURE THINS   | M ADDRESS  | milfo   | real  | 250. REC'D B              | y REGISTRAR<br>5 '60 |                               | TRAR'S SIGNA   |                           |                  |

may invariant by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by page 3 shauld be detached for use as the burial-transit permit. Then please remave obtain physics I and 2 the State Board of Health prior to burial, cremation, or remaval, and in any event, within 72-buye after death AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A

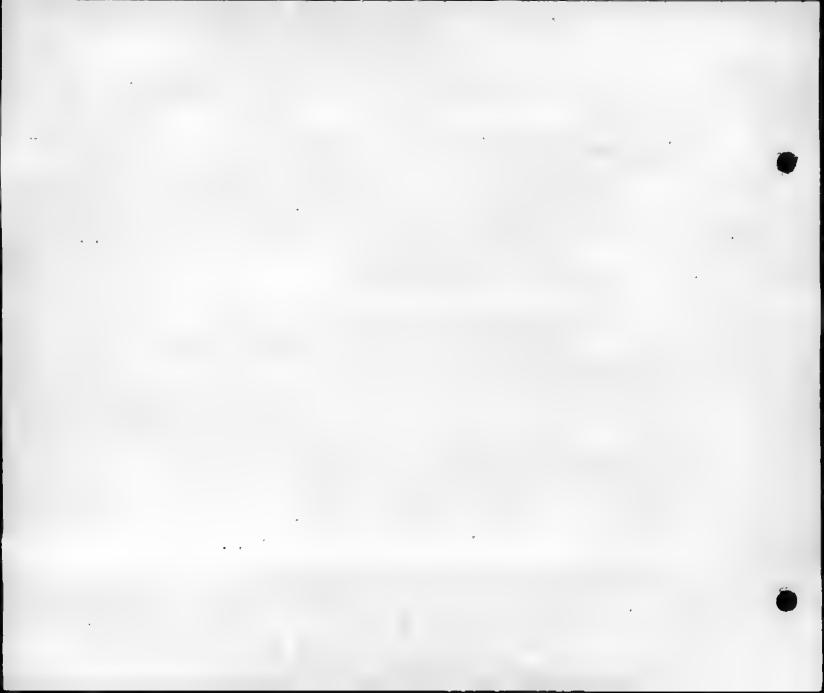
porban par

th, Poge 4

VR A15 (4) 15M 9/59 1000

TO HO

0 0/X114



LAND STATE DEPARTMENT OF HEALTH 1. PLACE OF DEATH a. COUNTY This certificate should be executed within 24 hours after death, . — delay is necessary, a word "pending" in pencil in Item 18. Give Peges 1, 2, and 3 to the funeral director. Page acids Examiner's Office along with form PM3. Page 5 may be retained for your files. And be used as a burial-transit permit. File pages 7 and 2 with the State Board Health, cremotal, and in any event within 72 hours after death. MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and sive neerest town d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, g ve NAME OF Middla DECEASED (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IDa. USUAL OCCUPATION (Giva kind of work 1Db. KIND OF BUSINESS OR INDUSTRY dona during most of working life, aven/if retired) ful selve 13. FATHER'S NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yas, no, or unkown) (Ifyas obvewar or datas of service) 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c).] IMMEDIATE CAUSE (a) DUE TO Conditions, it any, which please execute the certificate, writing the word "pending" 4 should be forwarded to the Chief Medical Examiner's CO FUNERAL DIRECTOR: Page 3 should be used as a be gave rise to immediate cause DUE TO (a), stating the underlying causa last. CERTIFICATION 20a EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING | ITY MEDICAL EXAMINER: CAUSE OF DEATH. CAL 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED Whila Not While Hour a.m. at work at work prior agent, death resulted from: Natural causes Accident Suicide its designated SIGNATURE NAME (Typa) 220. BURIAL, CREMATION, 225. DATE THEREOF 22c. REMOVAL (Specify) Burial 23. FUNERAL DIRECTO VS. A15ME

5M 7/59

**BALTIMORE 1. MARYLAND** 2. USUAL RESIDENCE (Where deceased leved, If institution: Residence before admission) b. COUNTY CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) . IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO P DATE Month Year OF DEATH 19 B. DATE OF BIRTH AGE (In years LIF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 12. CITIZEN OF WHAT COUNTRY? MOTHER S MAIDEN NAMI INTERVAL BETWEEN ONSET, AND DEATH 6 hz ? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(8) 19. WAS AUTOPSY PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of invery in Part II or Part II of them 18.) 2Da. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection IX. Inquiry and in my opinion Homicide Undetermined manner CHIEF MEDICAL EXAMINER [ ASSISTANT MEDICAL EXAMINER DATE SIGNED DEPUTY MEDICAL EXAMINER 1 DAddress (Streat, city, town, or county) NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or country) (Stata) Harmony Park Cem. Maryland 248. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE Chillian S. France DATE



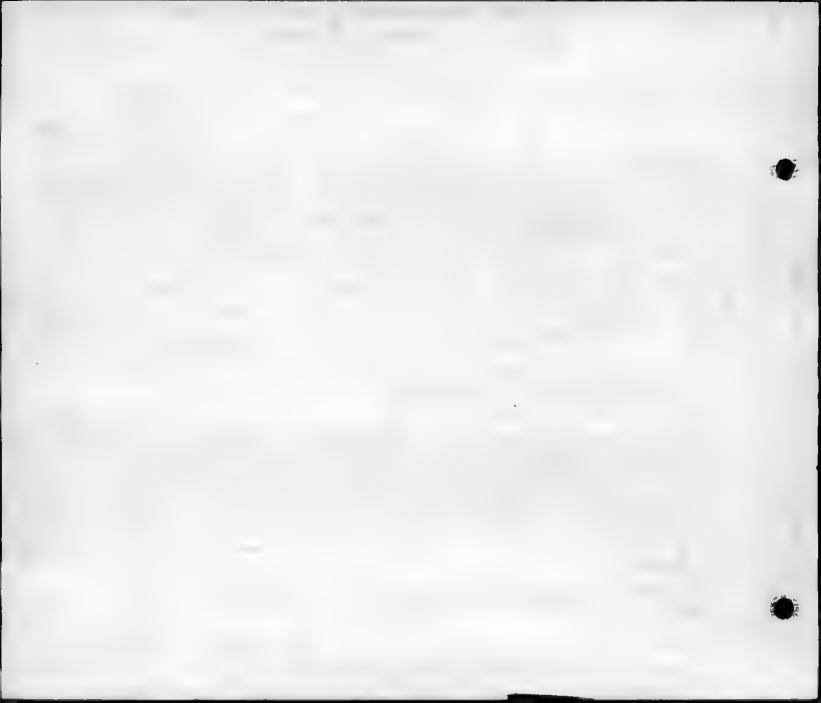
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may retained by the hospital or attending physician.

TO FULLAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filter in by the funeral director. page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

|   |  |   | 763   | [9]                            | CERTII                     | ICA           | TE OF DEATH  | 4 1                    |                              | Reg. Dist. N                | 0761                        | 00                        |
|---|--|---|---|--------------------------------|----------------------------|---------------|--|------------------------|------------------------------|-----------------------------|-----------------------------|---------------------------|
|   | 1. PLACE OF DEATH a. COUNTY ATATE  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence of STATE) b. COUNTY b. COUNTY |   |   |                                |                            |               |  |                        |                              |                             | fare odmiss                 | tion)                     |
|   |  | RURAL and give he   | autside carporate lim<br>arest town)              | its, write                     | c. LENGTH OF STAY I        | N 1b          | c. CITY OR TOWN (If o                                      | utside corporate       | limits, write RI             | IRAL and give r             | earest lawr                 | n}                        |
|   |  |   | AL (If not in hospital/)                          |                                | oddress)                   | 1             | d STREET ADDRESS   |                        |                              |                             |                             | FARM?                     |
|   |  | NAME OF<br>DECEASED "<br>(Type or print) -                  | T/200   | rst<br>«                       | , Middle                   | 1/            | / Lost   | 4. DATE<br>OF<br>DEATH | JUL                          |                             | -                           | Yeor<br>1960              |
|   | 5. 5   | SEX :   | 6. COLOR OR RACE                                  | 7. MARR                        | DIVORCED                   |               | DATE OF BIRTH  | > 9.                   | AGE (In years lost birthday) | Manths Days                 |                             | ER 24 HRS.                |
|   | 100  | during most of work   | N (Give kind of work<br>ing life, even if retired | dane 10b.                      | KIND OF BUSINESS OF        | INDUST        | RY 11. BIRTHPLACE (State                                   | ar foreign cauni       | (ער                          | 12. CITIZEN                 | OF WHAT                     | COUNTRY                   |
|   | 13   | FATHER'S NAME   | Thee.   | Ŕ                              | ( LEASO                    | 6.1           | 14 MOTHER'S MAIDEN N                                       | laye<br>Leyt           | , ( ,                        | 1.                          |                             |                           |
| \ |  |   | t IN U. S. ARMED FOR                              |                                | SOCIAL SECURITY NO         | 17, INI       | ORMANT - 1 m mm  | - 4                    | Addr                         | ess<br>M                    |                             |                           |
| / |  |   | TH WAS CAUSED BY:<br>IMMEDIATE CAUSE (c           | Zer                            | me for (o), (b), and (c) } | 320           | ncho pneu  | monia                  |                              | IN OI                       | TERVAL BE<br>NSET AND<br>24 | DEATH<br>HRS              |
|   | Conditions, if ony, which (b) Massive Cerebral Hemorrhage  |   |   |                                |                            |               |  |                        |                              | 2 mo                        | nthe                        |                           |
|   | 7  | couse (a), stating t<br>lying couse last.                   | he under-   | , Cer                          | ebral arte                 | uissa         | lerosis & He   | perter                 |                              |                             | 3 YR:                       | 5.                        |
|   | CERTIFICATION  |   |   |                                | ONTRIBUTING TO DEA         |               |  |                        |                              | EN IN PART 1(a)             | PERFO<br>YES                | AUTOPSY<br>PRMED?<br>NO 4 |
|   |  | 20a ACCIDENT WAS<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY I | CAUSE OF DEATH                                    | 206 DESC                       | CRIBE HOW INJURY OC        | CURRED        | (Enter nature of injury in I                               | Part I ar Part II :    | of item 18 )                 |                             |                             |                           |
|   | MEDICAL  | 20c. TIME OF INJURY<br>Hour a.m.<br>p. m                    | Manth, Day, Ye                                    | ar 20d. IN<br>While<br>at work | Nat while                  | Oe. PLAC      | E OF INJURY IHame, farm<br>rry, street, affice bldg , etc. | , 20f. (City or<br>)   | town)                        | (Cauni                      | v)                          | (State)                   |
| 1 |  | 21. I certify the   | at I attended the                                 | decease<br>                    | _ // *                     | 26<br>Jeath ( | 1960 to 11   | BM, fram H             |                              | ,that I last                |                             |                           |
|   |  | ACTUAL SIGNATURE OF   | thur La   | rlof                           | and Jr.                    | м             | o. Thount  | address (Street        | 20 and                       | dale)                       | 7                           | -28-6                     |
|   |  | PHYSICIAN'S A IN  | CTHUR L   | ANI                            | < FORD JR                  |               | Pas  | acleno                 | mas                          | ylan                        | 2                           |                           |
|   | 220  | BURIAL CREMAT OF  | 726 DATE THEREO                                   | OF Co                          | 22c NAME OF CEME           | ERY OR        | CREMATORY CALLEGY  | 22d. LOCATION          | N Kity, lawn, a              | r bounty)                   | (Stal-                      | e) /                      |
|   | 23.  | FUNGRAL DIRECTOR'S  | SIGNATURE   | -/                             | ADDRESS                    | 3             | 24a, REC'I<br>DATE   | JUL 2 9 1              |                              | TRAR'S SIGNAT<br>Cluthun 2. | URE<br>Kinn                 |                           |
|   |  |   |   |                                |                            |               |  |                        |                              |                             |                             |                           |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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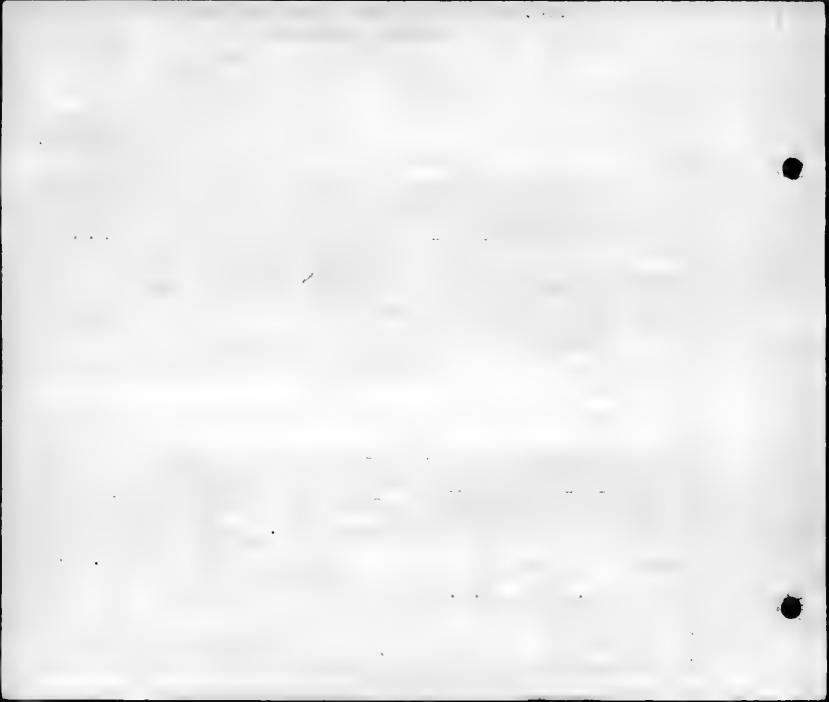
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|   |               |   | -1000   |                               | <b>-</b>                      | EKINIK        | -/      | E OF D  | ALC: I                      |               |                              | Reg. D               | st. No.  | O & C    | ) U JL          |  |
|---|---------------|---|---|-------------------------------|-------------------------------|---------------|---------|---|-----------------------------|---------------|------------------------------|----------------------|----------|----------|-----------------|--|
|   | 0             | LACE OF DEATH COUNTY Anne Arune   | ie <b>l</b>   |                               |                               | MARYLAND      | - 13    | usual resit<br>o. STATE<br>Mary:  |                             | ere deceased  | b. COUNTY                    | oni Residei<br>ÎMOPE | ce belor | e odmiss | ion)            |  |
|   | t             | CITY OR TOWN (I   | foutside corporate fim<br>arest lown)               | its, write                    | c. LENGTH C                   | OF STAY IN 16 | •       | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |                             |               |                              |                      |          |          |                 |  |
|   |               | Crown svil  | le  |                               |                               | 21 Pa         | y       | Baltimore SVA   |                             |               |                              |                      |          |          |                 |  |
| , | ٩             | d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |   |                               |                               |               |         | d. STREET A   | DORESS                      |               |                              |                      | 4        | IS RES   | IDENCE<br>FARM2 |  |
| à |               | Crownsvil   | <u>le State H</u>                                   | ospit                         | al                            |               |         | 1308  | Linde                       | en Ave        | nue                          |                      |          |          | NO 🗓            |  |
|   | 3. 1          | NAME OF<br>DECEASED   | Fi  | rst                           |                               | Middle        |         | Losi  |                             | 4. DATE<br>OF | Mon                          | th                   | Doj      |          | Yeor            |  |
| ı |               | Type or print)  |   | ola                           |                               |               |         | John  | son                         | DEATH         | 7                            |                      |          |          | 1960            |  |
|   | 5. 5          |   | 6. COLOR OR RACE                                    | 7. MARI                       |                               |               |         | ATE OF BIRTH  |                             |               | 9. AGE (In years instantion) | Months               | Days     | Hours    | ER 24 HRS       |  |
|   |               | Female  | Negro   | WIDOW                         |                               | IVORCED 🔀     | ٠       | rch 26  |                             |               | 10 113.                      |                      |          |          |                 |  |
|   | 10a           | during most of work Domestic  | N (Give kind of work<br>ing life, even if retired   | done 10b                      | KIND OF BUSI                  | INESS OR INC  | YATZUC  | 1   | yland                       | er foreign co | ountry)                      | 12 CI                |          | S.A.     | COUNTRY         |  |
|   | 13.           | FATHER'S NAME   | n 1. t  | HEN                           | 1A.S                          |               | 1       | 4 MOTHER'S  | MAIDEN N                    |               | irke                         |                      |          |          |                 |  |
| 1 |               |   | R IN U.S. ARMED FOI<br>If yes, give wor or doles of |                               | SOCIAL SECUI                  | RITY NO. 17   |         | RMANT<br>spital   | Reco                        | rds           | Add                          | ress                 |          |          |                 |  |
| A |               |   | TH [Enler only one co                               | nuse per li                   | ne for (a) (b)                | and (c) l     |         | 1, -  |                             |               |                              |                      | INTE     | RVAL BE  | TWEEN           |  |
|   |               |   | TH WAS CAUSED BY:                                   |                               | in the fall (a).              | Uremia        |         |   |                             |               |                              |                      | ONS      | ET AND   | DEATH           |  |
|   |               | 4 .   | IMMEDIATE CAUSE (                                   |                               |                               |               |         |   |                             |               |                              |                      |          |          |                 |  |
|   |               | Conditions, if a  | hy, which )   | )                             |                               | Pyonep        | hro     | sis   |                             |               |                              |                      |          |          |                 |  |
|   |               | gove rise to immediate DUE TO   |   |                               |                               |               |         |   |                             |               |                              |                      |          |          |                 |  |
|   |               | lying couse lost. (c) Carcinoma of Urinary Bladder  |   |                               |                               |               |         |   |                             |               |                              |                      |          |          |                 |  |
| 1 | CERTIFICATION | Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19 WAS AUTOPSY PERFORMED?  YES  NO |   |                               |                               |               |         |   |                             |               |                              |                      |          |          |                 |  |
|   |               | 200 ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY  | S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER) | 20b DES                       | CRISE HOW IN                  | JURY OCCUR    | RED. (E | inter noture of   | injury in P                 | ort I ar Port | It of item 18.)              |                      |          |          |                 |  |
|   | MEDICAL       | 20c. TIME OF INJUR<br>Hour o. m.<br>p. m.   | Y Month, Day, Ye                                    | or 20d. II<br>While<br>of wor | NJURY OCCUR Notwith k pr work |               | PLACE   | OF INJURY (I  | lome, form,<br>bldg., etc.) | 20f. (City    | or town)                     |                      | County)  |          | (State)         |  |
|   |               | 21. I certify th  | at 1 attended the                                   | deceas                        | ed fram                       | 6/1           |         | 1260  | , to 7                      | /21           | 19 60                        | that I               | last so  | w the    | decease         |  |
|   |               | alive on 7  | /21 /   | 19                            | 60                            | d that dea    | th ac   |   |                             | *M. fran      | n the causes o               | and an t             | he dat   | e state  | ed abave        |  |
|   |               |   |   | 1.                            | 124                           |               |         |   |                             | DDRESS (SI    | reet, city or town,          | slote)               |          | D/       | ATE SIGNED      |  |
|   |               | ACTUAL<br>SIGNATURE   | MICH  | in                            | KM.                           |               | M.D     | Cro   | wnsvi                       | lle S         | tate H <sub>o</sub> s        | pital                | , Md     | • 7      | /21/6           |  |
|   |               | PHYSICIAN'S<br>NAME (Type)  | L. Bened  | lict,                         | M. D.                         |               |         | Cro   | wnsvi                       | lle S         | tate Hos                     | pital                | , Md     | • 7      | /21/6           |  |
|   | 220           | BURIAL CREMATIO<br>TREMOVAL (Specify)   | N. 226. DATE THERE                                  |                               | 22c. NAME (                   | OF CEMETERY   | OR CI   | CE  |                             | 27d, 10CA1    | TION (City, town.            | or county)           | m        | (State   | e)              |  |
|   | 23.           | FUNERAL DIRECTOR  | S SIGNATURE   | 10. 0 23                      | ADDRESS                       | 5             | 1       |   |                             | BY REGIST     | RAR 24b REGI                 | STRAR'S SI           |          | E        |                 |  |

10 HOSELTAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 22 hours after death. Page 4 may etained by the hospital or attending physician.

TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with the registrar prior to burial, crematian, ar remaval, and in any event within 72 hours after death.

VS A15 (4) 1SM 9/S5



urs ofter death. Page

# MARYLAND STATE DEPARTMENT OF HEALTH Properties of Statistical Research and Records — Baltimore 1, Maryland CERTIFICATE OF DEATH

07602

| 1. PLACE OF DEATH<br>b. COUNTY  |  | _                                 | 2. USUAL RESIDENCE             |                       | lived. If institution b. COUNTY | Residence before a  | dmission)                 |
|---------------------------------|--|-----------------------------------|--------------------------------|-----------------------|---------------------------------|---------------------|---------------------------|
|                                 | Anne Arund   |                                   | Table y                        |                       |                                 | Anne Arur           |                           |
|                                 | N (If outside corporate limits, v<br>e nearest town)           | vrite c LENGTH OF STAY IN         | 16 c. CITY OR TOWN             | 1 (If outside carpora | ote limits, write RURA          | AL and give nearest | t town)                   |
| Arnapol                         |  | l day                             | - 14 - 25                      | AL - Edge             | water                           |                     |                           |
| d. NAME OF HO<br>OR INSTITUTION | SPITAL (If not in hospital, give                               | street oddress)                   | d. STREET ADDRE                | SS                    |                                 | e. 1                | S RESIDENCE<br>ON A FARM? |
| anne Arund                      | el General Hos   | spital                            | Rt-2,                          | Box-67                |                                 | Y                   | ES NO                     |
| NAME OF<br>DECEASED             | First  | Middle                            | Lost                           | 4. DATE<br>OF         | Month                           | Day                 | Year                      |
| (Type or print)                 | Edward   | F.                                | JONES                          | DEATH                 | Hul                             | y15                 | 1960                      |
| SEX                             | 6 COLOR OR RACE 7  | MARRIED NEVER MARRIED             | B DATE OF BIRTH                | 9                     |                                 | UNDER 1 YEAR IF     |                           |
| Male                            | White  w   | DOWED DIVORCED [                  | ] November 1                   | 4, 1910               | 49 yrs                          | ionths Days H       | ours Min.                 |
| On JSUAL OCCUP                  | AT ON (Give kind of work done working life, eyen) if setting() | 106 KIND OF BUSINESS OR I         | NDUSTRY 11. BIRTHPLACE (       | Stole or foreign cou  | untry)                          | 12 CITIZEN OF W     | HAT COUNTRY               |
| Industry                        | e al Kelation  | Indruster & Relie                 | tion Mi                        | ss ours               |                                 | U.S. /A             |                           |
| 3. FATHER'S NAME                |  |                                   | 14. MOTHER'S MAIL              | DEN NAME              |                                 |                     |                           |
| Cheery                          | en 13 to   | nes                               | Vena                           | Buck                  |                                 |                     |                           |
| 15 WAS DECEASED                 | EVER IN U S. ARMED FORCES                                      |                                   | Z INFORMANT                    |                       | Address                         | 13                  |                           |
| (ses no or openown)             | (1) yes, give war or dates of service                          | "                                 | Di within MI                   | orikana               | & tones                         | (2)                 |                           |
| TIB. CAUSE OF                   | DEATH [Enter only one couse                                    | per line for (o), (b), and (c), 1 | -                              |                       | -/-                             | INTERV              | AL BETWEEN                |
|                                 | DEATH WAS CAUSED BY  | 2 1/                              | POLIALLA                       | DAME                  | ~ A77 -                         | ONSET               | AND DEATH                 |
| Acres 1                         | IMMEDIATE CAUSE (0)  | HOUTE HEM                         | ORRHHOIC.                      | PATTOKI               | 11-1-1-1                        | 7 14                | MOUK                      |
|                                 | DUE TO   |                                   |                                |                       |                                 |                     |                           |
| Canditions, i                   | fony, which ) (b)  |                                   |                                |                       |                                 |                     |                           |
| gove rise to                    | immediate (  |                                   |                                |                       |                                 |                     |                           |
| lying couse lo                  | ing the order  |                                   |                                |                       |                                 |                     |                           |
|                                 | ,                        | ONS CONTRIBUTING TO DEATH         | BUT NOT RELATED TO THE         | TERMINAL DISEASE      | CONDITION GIVEN                 | IN PART 1(o) 19     | WAS AUTOPSY               |
| Z PART II                       |  |                                   |                                |                       |                                 | F                   | PERFORMED?                |
|                                 | WAS TINDERLYING D 208  | DESCRIBE HOW INJURY OCC           | JRRED (Enter noture of initial | ry in Port I or Port  | II of stem 1B )                 |                     | <u> </u>                  |
| OR CONTRIBUTE                   | WAS UNDERLYING   20k ING   CAUSE OF DEATH ITY MEDICAL EXAMINER |                                   | (50000 10000 00 70)            | ,                     |                                 |                     |                           |
|                                 |  | 20d. INJURY OCCURRED 20           | e. PLACE OF INJURY (Home       | , form, 20f (City o   | or town)                        | (County)            | (Stote                    |
| 20c TIME OF IN<br>Hour o.       | m.   | While Not while                   | foctory, street, office bldg   |                       | 0, 10,411)                      | (County)            | (300)                     |
| Σ p.                            | m. 19  | of work and of work               |                                |                       |                                 |                     |                           |
| 21 I certify                    | that (I) (this haspital) a                                     | ttended the deceased fro          | m December                     | , 1959 , to . s       | July 14                         | , 19_60, that       | (I) (@@): los:            |
| saw the dec                     | اللي acced alive on  | J. 19.60, and th                  | at death accurred at           | M, from t             | he causes and                   | an the date st      | ated abave                |
| 220 SIGNICUL                    | 0  | 121                               |                                | :00 A.F.              |                                 |                     | 22b DATE                  |
| 100                             | Duller 1   | Lasto.                            | M.D. PHYS XX                   | MED<br>DIRECTOR       | STAFF<br>PHYS                   | 7.                  | /15/60 EE                 |
| 22c. MATTELAN                   |  |                                   | 22d. ADDRESS                   |                       |                                 |                     |                           |
| NAME (Typ                       | Edward S. H  | Beck                              | 71 Fran                        | klin St               | Annapoli                        | s. Md.              |                           |
| 23a BUR AL CREMA                |  | 23c NAME OF CEMETE                |                                |                       | ION (City, town, or o           |                     | JStole)                   |
| REMOVAL (Spec                   |  | In Hopers                         | +menon                         | 0 /                   |                                 |                     | 12/4                      |
| V SWEAVERAL DIRECT              | ORS SIGNATURE  | ADDRESS                           | 250                            | REC'D BY REGISTR      | AP 25W PECISTE                  | AR'S SIGNATURE      | -                         |
| theym or,                       | 11 Fayler Sim  | o Gmas                            | Ot Mit                         |                       |                                 | - 4.                |                           |
| 1 "                             | /  |                                   | DAT                            | E JUL 18'6            | U Chil                          | wo S. Thrank        |                           |

TO HOSP ALOR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 2/mounting may

TO FUNERAL DIRECTOR: After this mertificate has been signed by the attending physician and completely filled in by
page 3 should be detached for use as the burial-transit permit. Then please remark carbon-gapers. Poges 1 and the State Board of Health prior to burial, cremotion, ar remayal, and in any event, within 72 hours, after death. ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 2,

VR A15 (4) 1SM 9/59



| - 1                              | 1  |     | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |
|----------------------------------|--|-----|--|
| 4 34                             | . H  | ,   | 7597 CERTIFICATE OF DEATH Reg. Did 18613   |
| Page 4                           | W  |     | 1. PLACE OF DEATH o. COUNTY A A  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY A A A   |
| death.                           | 90   | )   | b CITY OR TOWN (If outside corporate limits, write   c. LENGTH OF STAY IN 16   C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  ANNADOLIS  304EC ANNADOLIS  |
| irs ofter<br>by the f            | Should be should |     | d. NAME OF HOSPITAL (If not in hospital, give street oddress)  OR NSTITUTION  ON A FARM?  YES   NO   |
| filled in                        | es cu  |     | NAME OF DECEASED (Type or print) ISADEL TYLEF JONES DEATH 7 196  |
| pletely f                        |  |     | 5. SEX TO GO COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF, BIRTH 9. AGE (In years 1 YEAR IF UNDER 24 H WIDOWED DIVORCED Sept. 23-1891 8 Windows Windows Min  |
| cam                              | n pope<br>death.   |     | 100 USJA. OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) 11. BIRTHPLACE (State or foreign country)  AAA, CO, MA.  12 CITIZEN OF WHAT COUNTED  AAA, CO, MA.  |
| ا م                              | s after de   |     | HARDN TYLER HARRIETT SCALES  |
| certificate<br>ng physici        | 79 Tour  |     | IS. WAS DECEASED EVER IN U. S. ARMED/FORCES? 16. SOCIAL SECURITY NO. INFORMANT  Ver. no. fr upsnown)  (If yes, give wor or dofes of service)  NONE  ROSAMOND  Steed-916  Smithvill   |
|                                  | a pleose   |     | 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)  |
| that the                         | if. The  | 7   | Conditions, if ony, which ) (b)  |
| equires<br>in.<br>signed         | era<br>Pera<br>Pera<br>Pera  | . / | gove rise to immediate couse (a), stating the under- (c) (c)   |
| physicia<br>as been              | oval, ar   | *   | Z DESTRUCTION OF THE PROPERTY CONDITIONS CONTRIBUTION TO DESTRUCT TO THE FEDRINAL DISEASE CONDITION CIVEN IN PART 1(4) 19 WAS ALTOP  |
| ending<br>ficate h               | or rem   | 1   | PERFORMED?  YES NO [  OR CONTRIBUTING CAUSE OF DEATH   |
| PHYSIC<br>of or off<br>h s certi | use os   |     | 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a.m.  p. m.  19  20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State of the policy) (State of the |
| After t                          | ched far   | +   | 21. I certify that   attended the deceased from 1 = 3 = 3 = 10   10   10   10   10   10   10   10  |
| d by the                         | or to by   | ,   | ACTUAL SIGNATURE M.D () 1 Color of the state |
| AL O                             | shauld<br>strar pri  |     | PHYSICIAN'S AT ALLEN!  |
| O HO<br>may                      | page III<br>the regi   | 7   | 220 BJRIA., CREMATION, 226 DATE THEREOF 22C. NAME OF CEMETERY OF CREMATORY  BREMOVAL (Specify) 7-5-60 Brewer HILL ANNAPOLLS -Md.   |
| VS A15 (4<br>15M 9/5B            | t)   |     | 23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ANNA POLLS - Md. DATE JUL 12'60 CILLING S. PLISTAR'S SIGNATURE  C. E. HICKS TANNA POLLS - Md. DATE JUL 12'60  |



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# MARYLAND STATE DEPARTMENT OF HEALTH TO 9 SIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07604

| Male   White   WIDOWED   DIVORCED   May 8 1909   Start birthday)   Months   Do   SUAL OCCUPATION   Give kind of work done   10b. KIND OF BUSINESS OR INDUSTRY   BERLIFLAGE Sparse or foreign country)   12.CITIZEN   | before admission) Arundel   |  |  |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|--|--|
| OR INSTITUTION  Ame Arundel General Hospital    2/8 Wendover Road  | e nearest town)   |  |  |  |  |  |  |  |  |  |
| S. SEX SEX SOLOR OR RACE PART   SOLOR OR RACE   PART   SOLOR OR RACE   PARTIED   DIVERT MARRIED   DIVERT MARRIED MARRIED MARRIED MARRIED MARRIED   DIVERT MARRIED  | 6 IS RESIDENCE<br>ON A FARM?  |  |  |  |  |  |  |  |  |  |
| Dotale   C.   KENT   OF ATH   July   S.   SEX   S. COLOR OR RACE   7 MARRIED   NEVER MARRIED   B. DAJE OF BIRTH   SOUNDER IVINDER IV   | YES NO  |  |  |  |  |  |  |  |  |  |
| S. SEX   | Day Year  |  |  |  |  |  |  |  |  |  |
| Male   White   WIDOWED   DIVORCED   May 8 1909   Statisticidary)   Months   Do   Statisticidary   Months   Do   Maryland   12.CHIZEN  | 31 19 60<br>YEAR IF UNDER 24 HRS  |  |  |  |  |  |  |  |  |  |
| 10.0 JSUAL OCCUPATION (Give kind of work done of work done during most of work in file, even if retired)   12.CITIZEN  | Pays Hours Min.   |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME  George Kent  15. WAS DECASED EVER IN U. S. ARMED FORCES?  16 SOCIAL SECURITY NO  215-05-9456  Mrs. Louise E. Kent-248 Wendover Rose  18 CAUSE OF DEATH (Enter only one couse per rine for (o), (b), and (c).)  PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) ACCURE ANTERIOR MYSCAUSED BY IMMEDIATE CAUSE (o) thing the under couse (o), stating the und | 100 JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY HERTHPLACE (State or foreign country)  12.CITIZEN OF WHAT COUNTRY? |  |  |  |  |  |  |  |  |  |
| 15. WAS DECASED EVER IN U. S. ARMED FORCES?  16 SOCIAL SECURITY NO  215-05-9456  Mrs. Louise E. Kent-248 Wendover Rose  18 CAUSE OF DEATH [Enter only one couse per IPE for (a), (b), and (c).]  PART I DEATH WAS CAUSED BY [MMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCHROLA L. TNFARTION  DUE TO  Canditions, if any, which gave rise to immediate couse (a), stating the under lying couse last.  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  200 ACCIDENT WAS UNDERLYING DOWN OF DEATH ITE EITHER, NOTIFY MEDICAL EXAMINER;  200 ACCIDENT WAS UNDERLYING DOWN OF DEATH HOUR a.m. 19 and work Down of work Down of work Down of While Not wish Down of Work  |   |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 215-05-9456  NO 215-05-9456  18 CAUSE OF DEATH [Enter only one couse per Ine for (o), (b), and (c).]  PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) ACUTE ANTERIOR MYOCHROIDLE TNEARTION  DUE TO DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under lying couse last.  OF PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART IO CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  200 ACCIDENT WAS UNDERLYING While of work of wo |   |  |  |  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH   Enter only one couse per ine for (o), (b), and (c).     PART I DEATH WAS CAUSED BY   IMMEDIATE CAUSE (o)   AUTERIOR MYOCHED   AL TNEARTION     DUE TO   Canditions, if any, which gave rise to immediate couse (o), storing the under lying couse last.   (c)   DUE TO     Iying couse last.    | - 3   |  |  |  |  |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PRUTE ANTERIOR MYOCHROIDAL INFACTION  Conditions, if any, which gave rise to immediate cause (a), stating the under-lying couse last.  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (i)  200. ACCIDENT WAS UNDERLYING CAUSE OF DEATH III (if EITHER, NOTIFY MEDICAL EXAMINER)  200. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED How while at work of a work of the deceased dive an 19 attended the deceased fram July 15, 19 60 to July 31, 19 60 and that death accurred at M, from the causes and an the deceased dive an July 31 19 60, and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased dive an July 31 19 60, and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased dive an July 31 19 60, and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and that death accurred at M, from the causes and an the deceased fram July 15 19 60 and | INTERVAL BETWEEN  |  |  |  |  |  |  |  |  |  |
| Canditions, if any, which gave rise to immediate couse (a), storing the under-lying couse last.  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONTRIBUTION GIVEN IN PART I (c)  PART I. OTHER SIGNIF CANT CONTRIBUTION GIVEN IN PART I (c)  PART I. OTHER SIGNIF | ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |
| DUE TO   Stating the under-  lying couse last.   DUE TO     Stating the under-  lying couse last.   Cc      Part I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (   200 ACCIDENT WAS UNDERLYING   CAUSE OF DEATH     OR CONTRIBUTING   CAUSE OF DEATH     (IF EITHER, NOTIFY MEDICAL EXAMINER)     200. TIME OF INJURY MONth, Day, Year   Mulle   Aut while   at wark   ATTENDING   STAFF     21 I certify that (I) (this haspital) attended the deceased fram   July 15   19 60. to   July 31   19 60. The course of the courses and an the deceased alive an   July 31   19 60. and that death accurred at   M, from the causes and an the deceased fram   MD   ATTENDING   MED.   STAFF   MD     22c. PHYSICIAN'S   MAME (Type)   Arthur   R. Lankford   Jr.   Mountain   Road   Pasadena   Md   Mountain   Mountain   Mountain   Mountain   |   |  |  |  |  |  |  |  |  |  |
| DUE TO   Stating the under-  lying couse last.   DUE TO     Stating the under-  lying couse last.   Cc      Part I. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (   200 ACCIDENT WAS UNDERLYING   CAUSE OF DEATH     OR CONTRIBUTING   CAUSE OF DEATH     (IF EITHER, NOTIFY MEDICAL EXAMINER)     200. TIME OF INJURY MONth, Day, Year   Mulle   Aut while   at wark   ATTENDING   STAFF     21 I certify that (I) (this haspital) attended the deceased fram   July 15   19 60. to   July 31   19 60. The course of the courses and an the deceased alive an   July 31   19 60. and that death accurred at   M, from the causes and an the deceased fram   MD   ATTENDING   MED.   STAFF   MD     22c. PHYSICIAN'S   MAME (Type)   Arthur   R. Lankford   Jr.   Mountain   Road   Pasadena   Md   Mountain   Mountain   Mountain   Mountain   | ZHRS.   |  |  |  |  |  |  |  |  |  |
| Part I. Other significant conditions contributing to death but not related to the terminal disease condition given in Part II  200 ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18)  20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While   20e. Place Of Injury (Home, farm fociory, street, affice bldg., etc.)  20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While   20e. Place Of Injury (Home, farm fociory, street, affice bldg., etc.)  21 I certify that (I) (this haspital) attended the deceased fram July 15, 19, 60 to July 31, 19, 60 saw the deceased alive an July 31 19, 60, and that death accurred at M, from the causes and an the deceased street, and the deceased street, and the death accurred at M, from the causes and an the deceased street, and the deceased street, and the death accurred at M, from the causes and an the deceased street, and the deceased street, and the death accurred at M, from the causes and an the deceased street, and the dece |   |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at wark at war |   |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at wark at war | 1(a) 19 WAS AUTOPSY PERFORMED? YES NO   |  |  |  |  |  |  |  |  |  |
| 21 I certify that (I) (this haspital) attended the deceased fram July 15, 19 60 to July 31, 19 60, saw the deceased alive an July 31 19 60, and that death accurred atM, from the causes and an the deceased alive an July 31 19 60, and that death accurred atM, from the causes and an the deceased alive an July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased framM, from the causes   |   |  |  |  |  |  |  |  |  |  |
| 21 I certify that (I) (this haspital) attended the deceased fram July 15, 19 60 to July 31, 19 60, saw the deceased alive an July 31 19 60, and that death accurred atM, from the causes and an the deceased alive an July 31 19 60, and that death accurred atM, from the causes and an the deceased alive an July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60 to July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60, and that death accurred atM, from the causes and an the deceased fram July 15, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased fram July 31, 19 60, and that death accurred atM, from the causes and an the deceased framM, from the causes   | (State)   |  |  |  |  |  |  |  |  |  |
| 22c. Physician's NAME (Type)  22c. Physician's NAME (Type)  22c. Physician's NAME (Type)  Arthur P. Lankford, Jr.  22d. Address  Mountain Road, Pasadena, Md.  | O that (i) (w399ast   |  |  |  |  |  |  |  |  |  |
| Critical Lankford J. MD ATTENDING MED. STAFF PHYS.   22c. PHYSICIAN'S NAME (Type) Arthur R. Lankford, Jr. Mountain Road, Pasadena, Md.   | date stated above   |  |  |  |  |  |  |  |  |  |
| Arthur F. Lankford, Jr. Mountain Road, Pasadena, Md.   | 22b. DATE<br>SIGNED<br>\$-/-60  |  |  |  |  |  |  |  |  |  |
| Arthur R. Lankford, Jr. Mountain Road, Pasadena, Md.   |   |  |  |  |  |  |  |  |  |  |
|  |   |  |  |  |  |  |  |  |  |  |
| 23c BURIAL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town or county) Burial 8/4/60 Meadowridge Mem. Park Cem. Elkridge. Marvlan  | (Stote)   |  |  |  |  |  |  |  |  |  |
| Burial 8/4/60 Meadowridge Mem. Park Cem. Elkridge, Marylan 24 FUNERAL DIRECTOR'S GNAME ADDRESS 250 REC'D BY REGISTRAR 255 REG STRAK'S SIGNA  |   |  |  |  |  |  |  |  |  |  |
| am.g. Tickner Back -17 md DATEMIG 3 '60  |   |  |  |  |  |  |  |  |  |  |



|                             |   | 1000   |                     |                  |   |                        | Keg. L                               | list. No.   |
|-----------------------------|---|--|---------------------|------------------|---|------------------------|--------------------------------------|---|
| 1. PLACE<br>o. COL          | OF DEATH  | a  |                     | MARYLAND         | 2 USUAL RESIDENCE (V                                      |                        | . If institution Reside<br>b. COUNTY | mce before admission)                             |
| b. CITY                     | OR TOWN (If or  | itside corporate limi                                    | ts, write c. LENG   | TH OF STAY IN 16 | c. CITY OR TOWN (I  | f outside corporate li | mits, .write RURAL ond               | give nearest town)                                |
| d. NA/<br>OR                | ME OF HOSPITAL  | (If not in hospital, g                                   | tye street oddress) |                  | d STREET ADDRESS  | Mark                   | et St                                | e. IS RESIDENCE<br>ON A FARM?<br>YES NO           |
| 3. NAME<br>DECEA<br>(Type o |   | linds  | ew                  | Middle           | ramer &   | 4. DATE<br>OF<br>DEATH | July                                 | Day 14 4 19 60                                    |
| SSEX                        | ele !   | Write  | 7 MARRIED N         | EVER MARRIED     | B DATE OF BIRTH &   | 918 2                  | (b) years IF PNDE (b) Months         | R 1 YEAR IF UNDER 24 HRS Days Hours Min.          |
| 10a USU<br>durik            | R OCCUPATION of most of working                         | life, even if retired                                    | done 10b. KIND OF   | business or inc  | Postlan   | d Orac                 | 10n 12.c                             | 1. S. Q.  |
| 13. FATHE                   | ndre  | w a.   | Bran                | ner Er           | 14. MOTHER'S MAIDEN                                       | NAME PA                | ller                                 |   |
| {Yes no or                  | DECEASED EVER IN  | NOL I  | CES? 16. SOCIAL SI  | ECURITY NO 17    | MONCY!  | C. Kr                  | Address                              | , (2)   |
| 16.                         | PART I. DEATH   | Enter only one co<br>WAS CAUSED BY:<br>IMEDIATE CAUSE (o |                     | (b), and (c).]   | 1 de Ora  | Most                   |                                      | INTERVAL BETWEEN ONSET AND DEATH                  |
| gov                         | ditions, if ony,<br>e rise to imm<br>e (o), stoting the | which (b   | , that              | iguan            | 7 Hair  | LEVAL                  | <u> </u>                             | 1/41  |
| CATION                      | PART II. OTHER  | SIGNIFICANT CON  | DITIONS CONTRIBU    | TING TO DEATH B  | UT NOT RELATED TO THE TER                                 | MINAL DISEASE CON      | IDITION GIVEN IN PA                  | RT I(o) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO R |
| 200 /<br>OR C<br>(IF EI     | ACCIDENT WAS LONTRIBUTING []<br>THER, NOTIFY ME         | INDERLYING TO CAUSE OF DEATH DICAL EXAMINER)             | 20b. DESCRIBE HOV   | W INJURY OCCUR   | RED (Enter noture of injury i                             | n Port I ar Port II of | ilem 18 )                            |   |
| WEDICAL                     | Hour a.m.   | Month, Day, Yes  |                     | while            | PLACE OF INJURY (Home, for foctory, street, office bldg., | erm, 20f. (City or to  | wn)                                  | (County) (Slate                                   |
| 1 1                         | certify that  | I attended the   | deceosed fram       | , 1              | , 19 <u>.5</u> /, to<br>th occurred at 7.4                | / 3tm                  |                                      | lost saw the decease<br>the date stated abo       |
| ACTU                        | >   | wells.   | Viait               |                  |   | ADDRESS (Street,       | ily or town, state]                  | DATE SIGN   |
| PHYS                        | ICIAN'S E (Type)  | YMES R   | MARTI               | 1/2              | 63  | 44W S<br>ANNAR         | 14/5/100                             | L   |
|                             | AL, CREMATION,<br>DVAL (Specify)                        | 226 DATE THEREO  | 1960 M              | ME OF CEMETERY   | OR CREMATORY  | 22d LOCATION           | City, lawn, or county                | Snd   |
|                             | MAL DIRECTOR'S S  | 11 m ( // )  | Somo Cis            | mako             | r mal   | C'D BY REGISTRAR       | 246 REGISTRAR'S S                    |   |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
() () CERTIFICATE OF DEATH 7600

07606

|          | PLACE OF DEATH<br>a. COUNTY                                     | Anne Ar                                  | Indel              | AA A BAM A NATO          | 2 USUAL RESII           |               |                     | d It institution.  b. COUNTY A |                 |                      |
|----------|---|--|--------------------|--------------------------|-------------------------|---------------|---------------------|--------------------------------|-----------------|----------------------|
|          |   |  |                    | MARYLAND                 | 1                       | 1011 0 110    | nd                  | P.                             | nne Aru         |                      |
|          | <ul> <li>C TY OR TOWN (If a<br/>RURAL and give near</li> </ul>  |  | mits, write        | c LENGTH OF STAY IN 16   | c. CITY OR I            | OWN (If a     | utside carporate    | limits, write RUR              | At and give nea | rrest town)          |
|          | Anrapoli  |  |                    | 34 days                  | RUE                     | RAL -         | Odenton             |                                |                 |                      |
|          | d NAME OF HOSPITAL OR INSTITUTION                               | (If not in hospital,                     | give street o      | address)                 | d'STREET A              | DDRESS        |                     |                                | •               | e IS RESIDENCE       |
| A        | nne Arundel   | General                                  | Hospi              | tal                      |                         |               |                     |                                |                 | YES NO               |
|          | NAME OF   |  | First              | Middle                   | Las                     | t             | 4. DATE             | Manth                          | Do              | y Yeor               |
|          | DECEASED<br>(Type or print)                                     | Geo                                      | rge                |                          | LARE                    | TN            | OF<br>DEATH         | July                           | 24              | 19 60                |
| 5        | SEX 16  | . COLOR OR RACI                          | 0-                 | IEQ M NEVER MARRIED      | BAPATE OF BIRTI         |               |                     | GE (In years IF                |                 | IF UNDER 24 HRS      |
|          | ale   | Negro                                    | WIDOWE             | D DIVORCED               | July,                   | 10/           | 877                 | 6 7 yrs                        | Aonths Days     | Hours Min            |
| 100      | <ul> <li>USUAL OCCUPATION during most of garking</li> </ul>     | (Give kind of wor's life, even if retire | k done 10b. I      | KIND OF BUSINESS OR INDU | STRY   11 LATRTHPL      | ACE (State of | ar fareign countr   | γ) ΄                           | 12. CITIZEN OF  | WHAT COUNTRY?        |
| L        | Kul   | ores                                     |                    |                          | 1                       | iaryla        | .nd                 |                                | U.S             |                      |
| 13       | FATHER'S NAME   |  |                    | f 1'                     | 14 MOTHER'S             | MAIDEN N      | IAME                | 00                             | /               |                      |
|          | Hork  | 200                                      | 0                  | Larpin                   |                         | 121           | na                  | tols                           | nam             |                      |
|          | WAS DECEASED EVER I   | N U. S. ARMED FO                         |                    | SOCIAL SECURITY NO. 17   | FORMANT                 | 11            | of L                | Addres                         | 1 -             | - 1                  |
| 1        | , ,   | you give not or owner                    | 2/1                | 18-01-0940               | Sarfiel                 | ld,           | Larks               | no C                           | derdon          | I mol                |
|          | 18. CAUSE OF DEATH  | Enter only one                           | cause per lin      | e far (a), (b), and (c). | 6-7                     | ,             |                     |                                |                 | RVAL BETWEEN         |
|          | PART I. DEATH   | WAS CAUSED BY                            | (0)                | Proporal                 | 1 Ha                    | 1-120         | dino                | Las                            | ONS             | SET AND DEATH        |
|          | ~ ~ "   | DUE 1                                    |                    |                          |                         |               |                     |                                | -               | 3 - A - A Carlog - S |
|          | Conditions, if any  | 4.5                                      |                    |                          |                         |               |                     |                                |                 |                      |
|          | gave rise to imm  | nediate (                                | (b)                |                          |                         |               |                     |                                |                 |                      |
|          | lying couse last.   | under:                                   |                    |                          |                         |               |                     |                                |                 |                      |
| Z        |   | SIGNIFICANT CO                           | (c)<br>ONDIT ONS C | ONTRIBUTING TO DEATH BUT | NOT RELATED TO          | THE TERM!     | NAL DISEASE CO      | ND TION GIVEN                  | N PART 1(o) 1   | 9 WAS AUTOPSY        |
| FICATION |   |  | _                  |                          |                         |               |                     |                                |                 | PERFORMED?           |
| FIG.     | 20a. ACCIDENT WAS   | LINDERLYING ET                           | 20b DESC           | RIBE HOW INJURY OCCURRE  | D /Enter noture o       | f injury in F | Port I or Part II a | f item 18 )                    |                 | ICS CO NO ES         |
| CERT     | 20g. ACCIDENT WAS<br>OR CONTRIBUTING [<br>(IF EITHER, NOTIFY MI | CAUSE OF DEAT                            | H<br>)             |                          | - (amar marar a         |               |                     |                                |                 |                      |
| CAL      | 20c TIME OF INJURY  | Month, Doy, 1                            |                    |                          | ACE OF INJURY (         | Home, form    | , 20f (City or t    | awn)                           | (County)        | (Stote)              |
| MED      | p. m  | 19                                       | While of work      | Not while                | cio, y, arroar, critica | o olug , etc. | 1                   |                                |                 |                      |
|          | 21 I certify that   | (I) (this haspit                         | al) attend         | ed the deceased fram     | June 20,                | 12.           | 60, to Ju           | Ly 23,                         | , 19_60, th     | at (1) (VAL last     |
|          |   | d alive ansJ                             | uly 23             | م 9 60 , and that c      | leath accurred          | d at          | M, from the         | causes and                     | an the date     | stated above.        |
|          | 220 S CATURE  |  | 1                  | 1 Pm 1                   | ATTENDING               | 6:45          |                     | 7.55                           |                 | 226 DATE<br>SIGNED   |
|          | de  | ularis                                   | 134                | Karks/                   | MD PHYS                 |               |                     | TAFF<br>HYS []                 |                 | 7/25/60              |
|          | NAME (Type)   |  |                    | , –                      | 22d. ADDRI              | ESS           |                     |                                |                 | 17 27                |
|          |   | dward S.                                 | Beck               |                          | 71 51                   | ankli         | n St.,              | Annapoli                       | s, ld.          |                      |
| 23       | a BURIAL, GRENITAN  | 235. DATE THER                           | EOF /              | 23c NAME OF CEMETERY O   | R CREMATORY             |               | 23d LOCATION        | (City, tawn, ar                | county)         | [Stqte]              |
|          | DEMOVAL-(Specify)   | July 2                                   | 7/40               | Faulks.                  | 1                       |               | Oden                | don                            | A.A.            | not                  |
| 24       | FUNERAL DIRECTOR'S  | QNATURE!                                 |                    | ADDRESS                  | 0-                      | 25o REGY      | BYREGISTRAR         | 25b. REGISTI                   | RAR'S S GNATU   | RE                   |
| -        | Annil A   | Low                                      | Ain                | . Annaps                 | 1660                    | DATE          | 77,00               | C. li                          | -1 S. Has       | L4                   |
|          |   | /  |                    |                          |                         |               | -                   |                                |                 |                      |

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



### MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

#### CERTIFICATE OF DEATH

07668

|                                  | 7692   |                 | CERTIFIC             | CAIL      | OF DEAT                                |               |   |                              | -              | , , ,        | - ()                 |
|----------------------------------|--|-----------------|----------------------|-----------|--|---------------|---|------------------------------|----------------|--------------|----------------------|
| 1. PLACE OF DEATH                |  |                 |                      | - 11      | USUAL RESIDENCE                        | (Where        | deceased I                              | ived. If institution         | n: Residence b | efore adm    | ission)              |
|                                  | Anne Arunde  | el              | MARYLA               | IND       | Mary                                   | lan           | d                                       | 5 0001411                    | Ann e .        | Arund        | .el                  |
| b CITY OR TOWN<br>RURAL and give | (If autside carporate imit                                   | , write         | c. LENGTH OF STAY IN | l lb      | CITY OR TOWN                           | (If outsi     | ide corporal                            | te limits, write RU          | RAL and give   | nearest to   | wn)                  |
|                                  | apolis   |                 | l day                |           | RURAL                                  |               | David                                   | sonville                     |                |              |                      |
|                                  | TAL (If not in haspital, gr                                  | ve street       | address)             |           | d. STREET ADDRESS                      | 5             |   |                              |                | a IS R       | ESIDENCE<br>A FARM?  |
| Anne Arund                       | lel General I  | lospi           | ital                 | j j       | f                                      |               |   |                              |                | YES [        | _ NO _               |
| 3. NAME OF<br>DECEASED           | Firs   | ì               | Middle               |           | Last                                   | 4             | . DATE<br>OF                            | Month                        | h              | Day          | Yeor                 |
| (Type or print)                  | Erne   | st              | RAY                  |           | LONG                                   |               | DEATH                                   | July                         |                | 4            | 1960                 |
| S SEX                            | 6 COLOR OR RACE  | 7. MARE         | RIED NEVER MARRIED   | B D.      | ATE OF 8 RTH                           |               | 9                                       | AGE (In years tast birthday) | IF UNDER 1 Y   |              |                      |
| Male                             | White  | WIDOWI          | ED DIVORCED          | D No      | v. 21, 18                              | 392           |   | 67 yn                        | Months Do      | ys Hour      | s Min                |
| 10a JSUAL OCCUPAT                | ON (Give kind of work darking life, even if retired)         | ane 10b.        | KIND OF BUSINESS OR  |           |  |               | fareign cou                             | ntry)                        |                |              | COUNTRY              |
| Stationery                       |  |                 | US Gov               |           | Penns <b>y</b> l                       | Lvan          | ia                                      |                              | U              | .s.          |                      |
| 13. FATHER'S NAME                |  |                 |                      | 1.        | I. MOTHER'S MAIDE                      | EN NAA        | ΛE                                      |                              |                |              |                      |
| William H                        | lenry Long   |                 |                      |           | Arabell                                | a S           | ands                                    |                              |                |              |                      |
| 15 WAS DECEASED EV               | ER IN U. S. ARMED FORG                                       |                 | SOCIAL SECURITY NO   | 17 INFOR  |  | mhthu medini. | 4-4-4-4-1-4-1-4-4-4-4-4-4-4-4-4-4-4-4-4 | Addre                        | 955            |              |                      |
| no                               | _no_   |                 | 5-03-1365            | Mae M     | Long- N                                | life          | - same                                  | as # 2                       |                |              |                      |
|                                  | EATH   Enter only one cas                                    |                 |                      |           |  | /             |   |                              | į!             | INTERVAL     | BETWEEN              |
| PART E DE                        | ATH WAS CAUSED BY:   | 1               | 20                   |           | 10-1                                   |               |   |                              | (              | ONSET AN     | D DEATH              |
| 101                              | IMMEDIATE CAUSE (6)  | /_              |                      | Right     | 7-1-10                                 | The second    | 701                                     |                              |                | 0-1-         |                      |
|                                  | O DUE TO   | P               |                      |           |  | 0             | 0                                       | ,                            |                | 1-           | -                    |
| Conditions, if                   | immediate  | 11              | renewal              | alqu      | and                                    | 1             | in                                      |                              | /              | 1 toy        |                      |
| cause (a), statin                | g the under DUE TO   | a CV            | V                    | /         | 1                                      | 10 1          | 1 1                                     | 1. /                         |                | 211          | 111                  |
| lying cause lost                 | _ (c)  |                 | norma                | 7-r-ED    |  |               | and                                     | er/                          |                | To the       |                      |
| PART II. O                       | THER SIGNIFICANT CON   | DITIONS C       | CONTR BUTING TO DEAT | H BUT NO  | RELATED TO THE TE                      | ERMINA        | L DISEASE                               | COND FION GIVE               | EN IN PART 1(  | PER          | S AUTOPSY<br>FORMED? |
| 2                                |  |                 |                      |           |  |               |   | 1 7 . 10 .                   |                | YES {        | ] NO []              |
| OR CONTRIBUTION                  | VAS UNDERLYING (1) IG (1) CAUSE OF DEATH Y MEDICAL EXAMINER) | 206 DES         | CRIBE HOW INJURY OCC | URRED (E  | nter nature of injury                  | n Por         | i i or Port (                           | For item 18.)                |                |              |                      |
| 20c TIME OF INJU                 |  |                 | NJURY OCCURRED 20    |           | OF INJURY (Home, street, office bldg., |               | 20f (City o                             | r town)                      | (Cou           | nty)         | (State               |
| Hour o.m                         | 10   | While<br>of wor | Not while            | rociory   | , sireer, office blog.,                | elc.)         |   |                              |                |              |                      |
|                                  | nat (I) (this haspital)                                      | atleno          | led the deceased fr  | ram Ji    | ine 4.                                 | 10 6          | O to J                                  | uly 4,                       | 19 60          | that (I)     | (JOSC Inc            |
|                                  | ased alive an Jul  |                 | 19_60 , and the      | hat deat  |  |               |   |                              |                |              |                      |
| 220 SIGNATURE                    | A) A   | 4-173-          |                      | irai uedi |  | 20F           |   | ie cooses din                | J OII THE U    | Die sinie    | 226 DATE             |
| 0                                | eln !  | De              | ann 1.               | M.D.      | ATTENDING                              | MED           | otor 🗆                                  | STAFF PHYS                   |                | 2-           | SIGNE                |
| 22c PHYSICIAN'S                  |  |                 | -                    |           | 22d ADDRESS                            |               |   |                              |                |              | _/0                  |
| NAME (Type)                      | Edwin Davis  | , Ur            | •                    |           | 98 Cathe                               | edra          | il St.                                  | , Annapo                     | olis, M        | d.           |                      |
| 23a BURIAL, CREMAT               | ION. 236 DATE THEREO   | F               | 23c NAME OF CEMET    | ERY OR CR |  |               |   | ON (City, tawn, o            |                |              | tote)                |
| SEMOVAL (Specific Burial         | July 8.19  |                 | Glen Haven           |           |  |               |   | Burnie,                      |                | ,            |                      |
| 24 FUNERAL DIRECTO               |  | 7/              | / ADDRESS            |           | 25a                                    |               |   |                              | TRAR'S SIGNA   |              |                      |
| Hopping                          | 10/2 /// -/  | ,               | ,                    | ra        | DATE                                   | H             | REGISTR                                 | A .                          | Muy 8, 9       |              |                      |
| TIOPPITIE                        | THE TALK TONIE   | 3 6             | unnapolis. M         | C .       | DAIL                                   |               |   |                              | 200, 1         | + 2 min Call |                      |

Annapolis, Md.

TO HOST ALL BRATENDING INVICIAN: The last requires that the desired certificate be executed within 2 four after death. Page 4 may canned by the haspital or ottending physician.

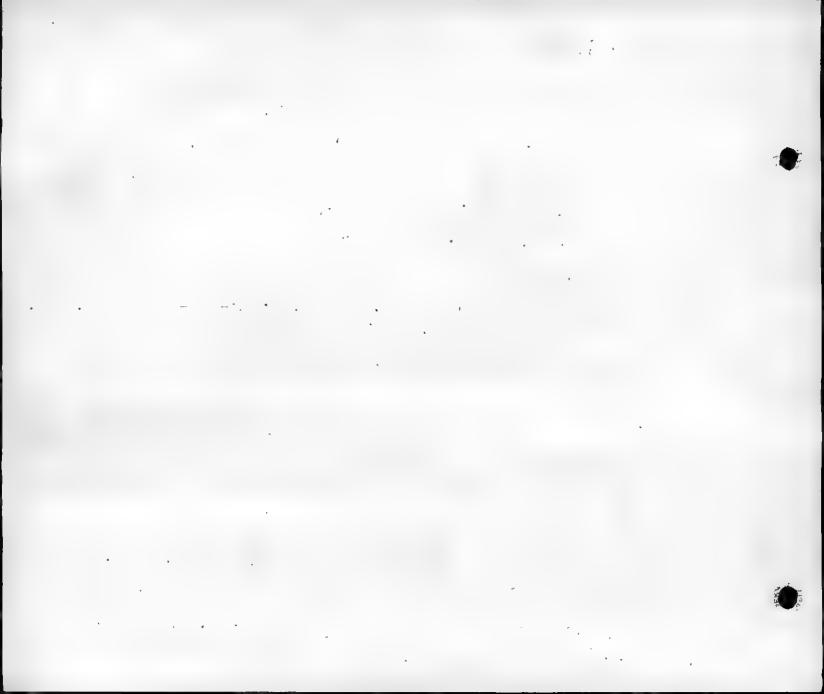
TO FUNERAL DISCUOR: After this centricate last been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbot pages 1 and 2, should be attended for use as the burial, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59



| 7 /   | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |
|---|--|
| * 2.5   | 7639 CERTIFICATE OF DEATH Reg. Dist. No. 7609  |
| i. Page 4   | 1. PLACE OF DEATH O COUNTY O STATE  2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) O. STATE D. COUNTY D. COUN |
| to 23   | b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest jown)  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
| by the fun  | d. NAME OF HOSPITAL (If not in hospital, give street oddress)  OR HASTITUTION  THE PROPERTY OF |
| 24.b  | 3 NAME OF DECEASED (Type or print) - Lover, White Per World Washington |
| d within 2  | S. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH  WIDOWED DIVORCED DEVORCED DIVORCED |
| nd camp   | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country)  12 CITIZEN OF WHAT COUNTRY  CLUB COUNTRY  |
| e pe di pe  | 13. FATHER'S NAME  |
| n certificating physical certains in the certain certain physical certain | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no or unknown)   11/1/198, give more or doke of service)   Note   Source as a confidence of the confiden |
| requires that the death ion. In signed by the attend nait permit. Then pleas and in any event within  | ART I DEATH WAS CAUSED BY.  Conditions, if ony, which gove rise to immediate couse (a), staling the under lying cause last.  (c)  INTERVAL BETWEEN ONSET AND DEATH  NTERVAL BETWEEN ONSET AND DEATH   |
| physic<br>as bell<br>iol-tra<br>loval,  | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? YES NO   |
|   | 20s. ACCIDENT WAS UNDERLYING   OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |
| PHYSIC<br>al ar at<br>this cert<br>r use as<br>emation  | 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour a.m.  P. m 19 While Nat while of work at work to work at work to work t |
| VITENDING  y the haspit TOR: After detached for ta burial, cr   | 21. I certify that I attended the deceased fram 1950, 19, to 19, that I last saw the deceased alive an 1900, 19, and that death accurred at 1900, from the causes and an the date stated above ADDRESS (Street, city or town, state)  DATE SIGNED  |
| ITAL OR ined by Shavid be strar prior   | PHYSICIAN'S NAME (Type) To COLD TO THE TOTAL DIED TO THE D |
| may b<br>may b<br>page 3<br>the regi  | 220. BURIAL CREMATION, 226 DATE THEREOF 220 NAME OF CEMETERY OR CREMATORY 22d LOCATION (City) town, or coupty) (Stole)   |
|   | 23 ENERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE LEVEL TO DATE AS 160 Children & Known  |





Item 7 CERTIFICATE OF DEATH 7640 Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH a COUNTY **b.** COUNTY MARYLAND ANNE AKUNDEL ANNE ARUNDEI CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town) DAVIDSONVILLE . IS RESIDENCE d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS OR INSTITUTION ON A FARM? YES NO NAME OF Middle 4. DATE Last Month Year DECEASED OF DEATH LINGINIA (Type or print) 1960 9. AGE (Ip years last birthday) IF UNDER LYEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BURTH Months Ma 87 yrs. WIDOWED PA DIVORCED [7] Female 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) USA own home House wife Germany 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME (Unknown) Brugger Clemank Greisl 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address Thomas E. Mayr- Son- Same as # 2 none 1B CAUSE OF DEATH [Enter only one couse per line for [o], (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (0) 7 0545 **DUE TO** caldictascula. Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the undersease and Semil lying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19 WAS AUTOPSY PERFORMED? YES NO [7] 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of ilem 18.) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING | CAUSE OF DEATH 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY IHome, form, 20f. (City or town) Doy, Year 20d. INJURY OCCURRED (County) (Stote) factory, street, affice bldg., etc.) Hour o. m. While Not while of work of work 21. I certify that I attended the deceased from Utily 302 1960 to July 31, 1964, that I last saw the deceased 6.0... and that death accurred at 10100 AM, from the causes and an the date stated above. ACTUAL PHYSICIAN'S

22c. NAME OF CEMETERY OR CREMATORY.

Our Lady of Sorrous

**ADDRESS** 

Annapolis, Md.

22d. LOCATION (City, lown, or county)

Maruland 246. REGISTRAR'S SIGNATURE

Querswille

24g, REC'D BY REGISTRAR

DATE AUG 4

funeral 90 should gud pup physician attending é TO FUR

quires that the death certificate

I director, filed with

ofter death. Page

VS A15 (4) 15M 9/55

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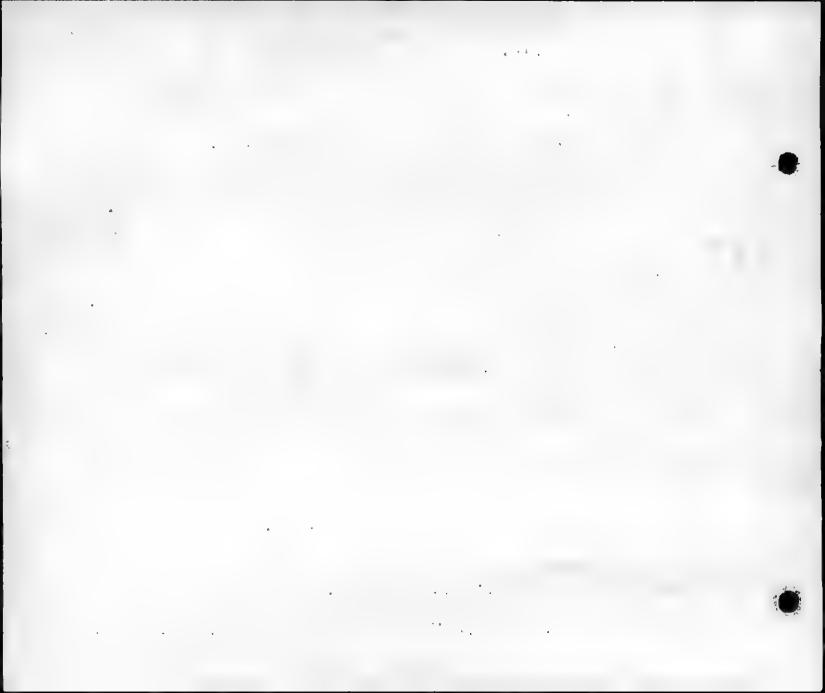
NAME (Type)

REMOVAL (Specify)

23 FUNERAL DIRECTOR'S SIGNATURE

220 BURIAL, CREMATION, 226 DATE THEREOF





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

director,

the funeral should be (F)

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burial-transit

detached

DIRECTOR:

Z OZ

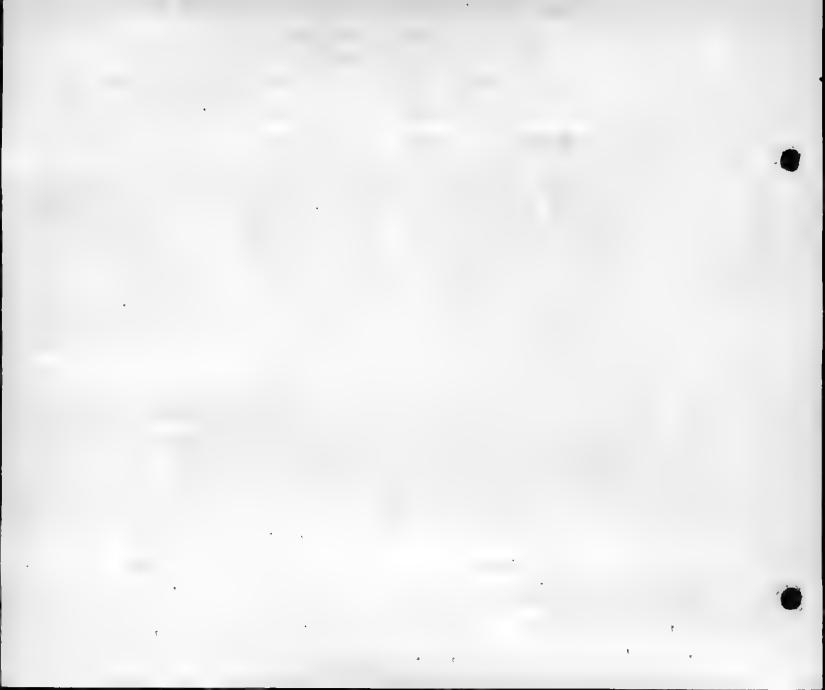
VS A15 (4)

15M 10/57

the

pup

after death? Page



|   |                                     | •  |  |  |   |
|---|-------------------------------------|--|--|--|---|
|   |                                     | t. After this certificate has been signed by the attending physicion and completely filled in by the funeral director, | ached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with | Erech within 72 haurs after death.   |   |
|   |                                     | ttendir  | plegse   | 700  | 1 |
| 3 |                                     | the at   | Then   | and in   | - |
|   | ie haspital ar ottending physician. | 3: After this certificate has been signed by t   | sched for use as the burial-transit permit. I  | Ilth prior to burial, cremation ar remayal, and in government within 72 haurs after death. |   |

VR A1S (4) 1SM 9/59

|   | PLACE OF DEATH                   | Locared   |                | MARY             | LAND     | 2 USUAL RESIDENCE (Who o. STATE  | ere deceased  | b. COUNTY                       |              |              | itssion)            |  |  |
|---|----------------------------------|---|----------------|------------------|----------|----------------------------------|---------------|---------------------------------|--------------|--------------|---------------------|--|--|
|   |                                  | Arundel f outside corporate limits,                 | write c LE     | NGTH OF STAY     | IN 16    | Maryland                         | uteida saraa  |                                 | ince G       |              | wa)                 |  |  |
|   | RURAL and give ne                | earest town)  |                |                  | 15 4 750 |                                  |               |                                 |              |              |                     |  |  |
|   | Glen Buri                        | N12<br>AL (If not in hospitol, giv                  |                | days             |          | Cedar Heigh                      | 165           | <u> </u>                        |              | - 10.0       |                     |  |  |
| 3 | OR INSTITUTION                   |   |                | ssi              |          |                                  |               |                                 |              | ON           | ESIDENCE<br>A FARM? |  |  |
|   |                                  | anor Nursing  | g Home         |                  | 1        | 6407 Kolb St                     | treet         |                                 |              | YES          | □ NO 🖪              |  |  |
| ď | 3 NAME OF<br>DECEASED            | First   |                | Middle           |          | Lost                             | 4. DATE<br>OF | Mon                             | ith          | Day          | Year                |  |  |
| , | (Type or print)                  | Rosa  | Mille          | r                |          |                                  | DEATH         | July                            | 4            |              | 1960                |  |  |
|   | S SEX                            | 6 COLOR OR RACE 7                                   | - MARRIED      | NEVER MARRIE     | D 🔲      | B DATE OF BIRTH                  |               | 9. AGE (In years last birthday) |              |              |                     |  |  |
|   | Female                           | Negro V   | WIDOWED 📳      | DIVORCE          |          | 5-10-1893                        |               | 67 yrs                          | Months D     | Days Hour    | rs Min              |  |  |
|   | 10g USUAL OCCUPATIO              | ON (Give kind of work do                            | ne 10b. KIND   | OF BUSINESS O    | R INDUS  | TRY 11 BIRTHPLACE (Stole         | or fore gn co | ountry)                         | 12 CITIZI    | EN OF WHAT   | COUNTRY             |  |  |
| 4 | Housewife                        | king life, even if retired)                         | Oran           | Home             |          | Unknown                          |               |                                 | II           | S.A.         |                     |  |  |
|   | 13 FATHER'S NAME                 |   | OWIL           | 1101.16          |          | 14 MOTHER'S MAIDEN N             | IAME          |                                 | 0.           | Usha         |                     |  |  |
|   | 77. 1                            |   |                |                  |          |                                  |               |                                 |              |              |                     |  |  |
|   | Unknown  IS WAS DECEASED EVE     | R IN U. S. ARMED FORCE                              | S2 34 SOCIA    | N SECURITY NO    | 17 16    | Unknown                          |               | Add                             |              |              |                     |  |  |
| 1 | (Yes, no or unknown)             | (If yes, give war or dates of serv                  | rice)          | AE SECURITY INC  |          |                                  |               |                                 |              |              |                     |  |  |
| 1 | No                               |   | Non            |                  |          | rs. Wesley-D.J                   | P.WF          | <u>rince Ge</u>                 | orge C       | o.Md.        |                     |  |  |
|   |                                  | TH [Enter only one cous                             | e per line for | (o) (b), ond (c) |          |                                  |               |                                 |              | INTERVAL I   | BETWEEN             |  |  |
|   | , PART I DEA                     | TH WAS CAUSED BY: IMMEDIATE CAUSE (6)_              | Arter          | iosclero         | tic      | cardiovascula                    | ar dis        | ease                            |              |              | VYS.                |  |  |
|   | LLLI                             | DUE TO  |                |                  |          |                                  |               |                                 |              |              |                     |  |  |
|   | Conditions, if or                | nv. which )   |                |                  |          |                                  |               |                                 |              |              |                     |  |  |
|   | gove rise to it                  | mmediate (  |                |                  |          |                                  |               | -                               |              | -            |                     |  |  |
|   | couse (a), stating               | the under-  |                |                  |          | P. C.                            |               |                                 |              |              |                     |  |  |
| 1 |                                  | FER SIGNIFICANT CONDI                               | TIONS CONTR    | PRUTING TO DEA   | TH RUT   | NOT RELATED TO THE TERMI         | NIAL DICEAL   | E CONDITION CO                  | CALIA, DAGT  | 1/-1 10 14/4 | E AUTORCY           |  |  |
|   | E                                |   |                |                  |          |                                  | IAME DIREVRI  | COMPITION GIV                   | EN IN FARI   | PERF         | FORMED?             |  |  |
|   | Genera                           | l debility a  |                |                  |          |                                  |               |                                 |              | YES [        | NO                  |  |  |
|   | OR CONTRIBUTING                  | S UNDERLYING 20 20 CAUSE OF DEATH MEDICAL EXAMINER) | OB. DESCRIBE   | HOW INJURY OF    | CORRE    | D. (Enter noture of injury in P  | off I or Port | Flot item 18 ]                  |              |              |                     |  |  |
|   | 20c. TIME OF INJUR<br>Hour o. m. | Y Manth, Doy, Year                                  | 20d. INJURY    | OCCURRED         | 20e. PLA | CE OF INJURY (Home, farm,        | . 20f (City   | or town)                        | íCo          | unty)        | (Stote              |  |  |
|   | Hour o.m.                        | 19  | While I        | Nat while        | foc      | lory, street, office bldg., etc. | )             |                                 |              | ,,           |                     |  |  |
|   |                                  |   |                |                  |          |                                  | -             | 1                               |              |              |                     |  |  |
|   | 21. I certify tho                | t (I) (this-hospital)                               |                |                  |          | June 25, 12.                     |               |                                 |              | ), that (I)  |                     |  |  |
|   |                                  | ed alive an July                                    | 7_2,           | 14_60, and       | that d   | eoth occurred at 3A.             | M, from       | the couses on                   | d on the     | dote state   | d obove             |  |  |
|   | 220 SIGNATURE                    |   | 11.            |                  |          |                                  |               |                                 |              |              | 22b DATE<br>5 GNEE  |  |  |
|   | 110                              | amos /  | 1. 1           | aur              | 1        | M.D. PHYS ATTENDING ME           | RECTOR [      | STAFF<br>PHYS                   | Ju           | dv L.1       | 1960                |  |  |
|   | 22c PHYS CYAN S<br>NAME (17pe)   |   |                |                  |          | 22d ADDRESS                      |               |                                 |              |              |                     |  |  |
|   |                                  | James M. Pai  | ir, M.D        |                  |          | 400 N. Car                       | rrollt        | on Avenu                        | e Balt       | 0.23,N       | id.                 |  |  |
|   | 230 SURIAL, CREMAT O             | N 23b, DATE THEREOF                                 | 23c            | NAME OF CEME     | TERY OF  | R CREMATORY -                    | 23d 2f0(CAT   | ION (C'ty town, s               | יו במו פוצו  | 151          | lote)               |  |  |
|   | REMOVAL (Spec.fy)                | 7-7-60  | 200            | 14 m             | bil      | Ch less                          | 10            |                                 | mal          | Men          | 1/ 2                |  |  |
|   | 24 FUNERAL DIRECTOR"             | S S GNATURE   |                | ADDRESS          | Juy.     | 25a REC'U                        | BY REGIST     | PAR 254 PECH                    | STRAR'S SIGN | JATURE !     |                     |  |  |
|   | 41000                            | 5/11  | 1.             | 11/              |          | DATE JU                          |               | 0                               | . 1          | House        |                     |  |  |
|   | 11/vith                          | VIII No.  | 1.12.01        | 14 4 -           | ~/       | DATE JU                          | F A 0         | 6.12                            | 1 miles      | C STA        |                     |  |  |

4925-Deare and N.E.

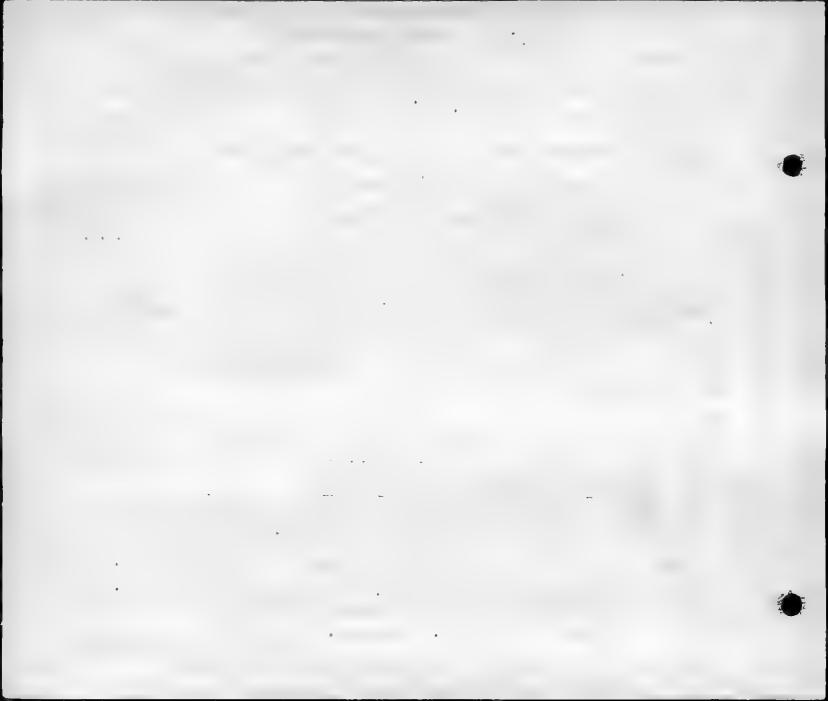


| 1  |     |             | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |
|--|-----|-------------|--|
| FOR ST   | ATE |             | 7604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.  |
| HEALTH   |     | -           |  |
|  |     | 1 0         | PLACE OF DEATH  2. USUAL TRESTORTICE (Where decosed lived, If institution, Roundence before admission)  5. COUNTY  O. STATE  |
| Page<br>files<br>Heolth,   |     |             | MARYLAND HIMAGING CA!  |
| sory, p  | M   |             | S. CITY OR TOWN (1 outside corporate limits A rife RURAL and give negress fown)  |
| 20 00  |     |             | NAME OF HOSPITAL ARANSTITUTION (If not in bospital) give street address?    d STREET ADDRESS   |
| s ned<br>ol du<br>red for  | 63  | 4           | le a Benegal Hospital 792 par Road VES IN NOX  |
| he Sto   |     |             | NAME OF DECEASED (Type or print) ( MILLO W Month Day Year DECEASED DECEASED) (Type or print) ( Manth Day Year DEATH TO DAY YEAR DEATH DEATH TO DAY YEAR DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH DAY YEAR DEATH TO DAY YEAR DEATH TO DAY YEAR DEATH DAY YEAR DAY YEA |
| to the   |     | 5, 5        | SEX OF GOLDER OF BACE 7. MARRIED NEVER MARRIED S 8 DATE OF BIRTH 9. AGE (In yours four burthday) Months Days Hours Min.  |
| 2 wil  |     | ļ,          | MICCE   WIDOWED   DIVORCED   1-1-1960   Yrs  |
| 2. ar  |     | 10a         | . VSUAL OCCUPATION (Give kind of work done 106 KIND OF BUS NESS OR INDUSTRY 11 BIRT-PLACE (Store of Resign country)  12 CITIZEN OF WHAT COUNTRY?   |
| es 1,  | _   | 13.         | FATHER'S NAME A TEMPTHER'S MAIDEN NAME   |
| Page   |     |             | Charles Molbrea Mary Clendenin   |
| form File  |     | 15.<br>(Ye) | WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO WINFORMANT Address (17 year give wor or dates of service)   |
| Ser  |     |             | Mary Cleuden 798 Da. Kd.   |
| d in   |     |             | 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), (c) and (c), (d) and (d), (e) and (e), (e) and (e), (f) and (f |
| d de la constante de la consta |     |             | PART I. DEATH WAS CAUSED BY: [ Style   Company   Company |
| fice<br>from   |     |             | 12.4 + O DUE TO  |
| Pario I  |     |             | Condificans, iff any, which agove rise to immediate cause  |
| of the state of th |     |             | (a), stating the underlying DUE TO   |
| sha<br>ami<br>as a<br>fian   | 6   | z           | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY   |
| pendingle pendingle col Ex   |     | ICATIO      | PERFORMED? YES NO  |
| Aedi al  |     | CERTIF      | 200. EXTERNAL CALSE WAS  200. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18)  PRIMARY (I or CONTRIBUTING )  CALSE OF DEATH.   |
| Th's<br>ef A<br>outo   |     |             | 20c, TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED, 20e PLACE OF INJURY (Home, form, 120f, (Cyty or town) (County) (State)  |
| Charles of the Charle | 0,0 | WEDICAL     | Hour a. m While Not while factory, street, office bldg, etc.)  While Not while factory, street, office bldg, etc.)   |
| Poge price   | 17  |             | 21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . and in my  |
| ed ?   |     |             | opinian death resulted from Matural causes . Accident . Suicide . Hamicide . Undetermined manner   |
| Pord<br>CTC  | 1   |             |  |
| Form   | 0   |             | SIGNATURE LES LUE LUE LES LA M.D CHIEF MEDICAL EXAMINER []  DATE SIGNED  |
| AE Be  |     |             | EXAMINER'S F / WFO/SF ASSISTANT MEDICAL EXAMINER ()  |
| 1000円  |     | -           | NAME (Type) / L/N MTTALY DEPUTY MEDICAL EXAMINER D   |
| T Show   |     | 720         | BURIAL CREMATION 726 DATE THEREOF 226 NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, Town, or county)   |
| 5 . 5  |     | 75          | VUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 RECUSTRARS 1240 RECUSTRARS SIGNATURE  |
| VS. ATSME<br>8M 2/57   |     | 1           | Willem Beesett (11100) ( pare 190 7 4 60 Cultury & Thomas  |
| 12 8   | 4   | +           | 2039181xV4   |
|  |     |             |  |



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

filed uneral 8 should within 0



ours ofter death. Page 4 may lained by the haspital or attending physician.

O FU DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 shauld be filled with the registrar prior to burial, crematian, ar removal, and in any event within 72 hours after death. INLOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2

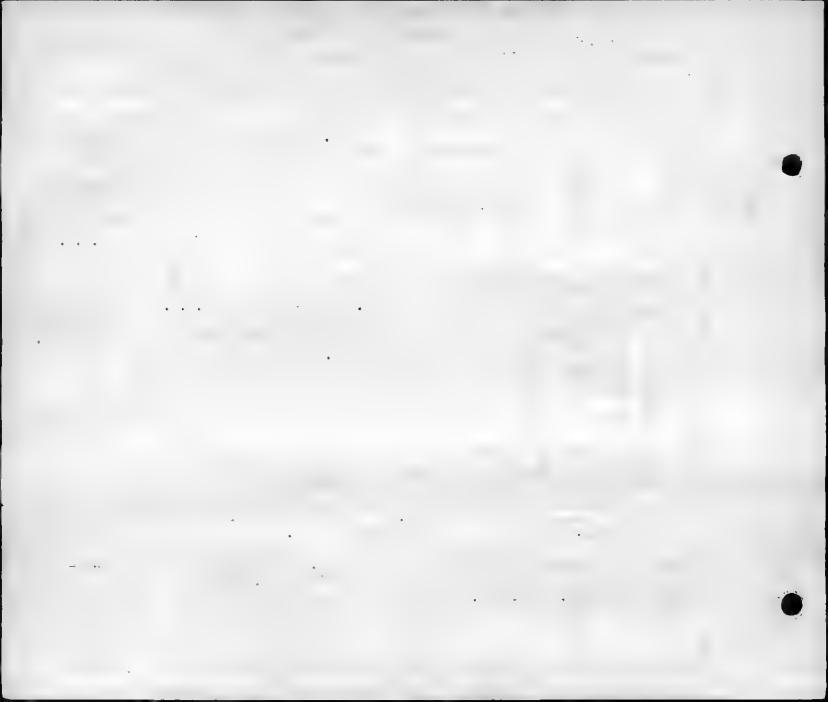
TO FU

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 645 | CERTIFICATE | OF DEATH |
|-----|-------------|----------|
|     |             |          |

Reg. Dist. Nol 7617

| 1. PLACE OF DEATH  o. COUNTY   |   |                                    | 2. USU          | AL RESIDENCE (Wh  | ere deceased                        |   |               | before admi | ision)                     |  |
|--|---|------------------------------------|-----------------|---|-------------------------------------|---|---------------|-------------|----------------------------|--|
| Anne   | Arundel   | MARYLAND                           |                 | Maryla  | and                                 | b. COUNTY   |               |             | V                          |  |
| B CITY OR TOWN RURAL and give Glen Br                                  |   | c. LENGTH OF STAY IN 16            |                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)  Baltimore |                                     |   |               |             |                            |  |
| OR INSTITUTIO  | PITAL (If not in hospital, give streets)  NOT Nursing Horse   | et oddress)                        |                 | W. Fayet  | te Str                              | reet  | 1             | ON          | SIDENCE<br>A FARM?<br>NO 1 |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)                              | Final<br>Elizabeth Park                                       | Middle<br>Cer                      |                 | Lost  | 4. DATE<br>OF<br>DEATH              | July 2  |               | Doy         | Yeor<br>19                 |  |
| 5. SEX   | 6. COLOR OR RACE 7. MA  | RRIED NEVER MARRIED                | B. DATE         | OF BIRTH  | 9                                   | AGE (In years   | IF UNDER 1    | YEAR IF UND | ER 24 HRS                  |  |
| Female   | Negro wipo  | WED DIVORCED                       | 18              | 6L  |                                     | lost birthdoy)<br>96 yrs  | Months E      | oys Hours   | Min,                       |  |
| 100. USUAL OCCUPA<br>during most of w<br>unknown                       | TION (Give kind of work done 10 orking life, even if retired) | b. KIND OF BUSINESS OR IND         | USTRY 11        | unknown   | or foreign cou                      | inlη)   | 12. CI112     | U.S.        |                            |  |
| 13. FATHER'S NAME  |   |                                    | 14, M           | THER'S MAIDEN N   | IAME                                |   |               |             |                            |  |
| Unkno  | own   |                                    |                 | Unknown   |                                     |   |               |             |                            |  |
| ts. WAS DECEASEDE  | VER IN U. S. ARMED FORCES? 1                                  |                                    | INFORMA<br>Mrs. | π<br>Rainey-Ba  | ltimor                              |   | dress         |             |                            |  |
| Conditions, if<br>gove rise to<br>cause (a), static<br>lying couse los | ony, which immediate out to out to                            | teriosclerotic hronic brain s      | yndro           | me.   |                                     |   |               | 1(a) 19 WAS | DRMED?                     |  |
| 1 - 1  | NG CAUSE OF DEATH   | ESCRIBE HOW INJURY OCCURR          |                 |   |                                     |   |               |             |                            |  |
| 20c. TIME OF INJ   | n. 19 Whi<br>n. 19 of w                                       | m Not while fark of work           | actory, stre    | WURY (Home, farm,<br>it, office bldg., etc.   |                                     |   | Ì             | unly)       | (Stole)                    |  |
| 21. I certify alive an JU  | that I attended the decent                                    | ased from July 8, 60 and that deat | h accurr        | od at 3. P.<br>OO N. Car  | _M, from<br>ADDRESS (Sind<br>rollto | the couses on the court of the | and an the    | date stat   | ed above.<br>ATE SIGNED    |  |
|  |   | M.D                                |                 | ltimore   |                                     |   |               |             |                            |  |
| Burial   |   | Mt. Aubur                          |                 | metery  |                                     | on (City, town,<br>Ltimore  |               | yland       |                            |  |
| 23. FUNERAL DIRECTO  | 1/  | ADDRESS<br>802 Madison             | Ave.            | 1   | 2 7 '60                             | 1   | ISTRAR'S SIGN | NATURE      |                            |  |



VR A1S [4] 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07618

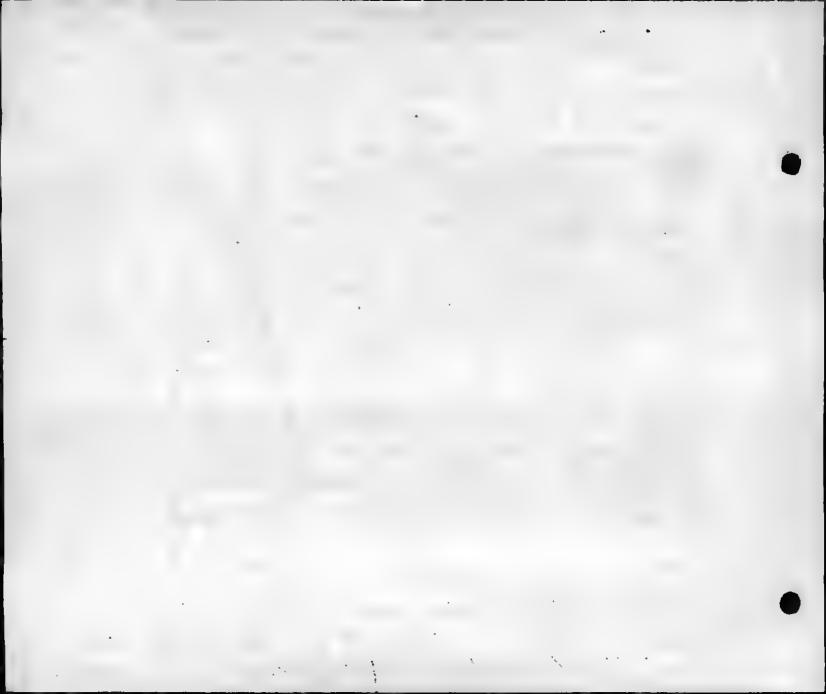
| 1. PLACE OF DEATH  |  |   |                   | 2, USUAL RESIDENCE                                  | (Where deceased    |                                 | n: Residence bef | fore admiss  | ion)              |
|--|--|---|-------------------|---|--------------------|---------------------------------|------------------|--------------|-------------------|
| a. COUNTY  | Anne Arunde  | 1   | MARYLAND          | o. STATE Mar  | yland              | b. COUNTY                       | Anne Ari         | undel        | ,                 |
| RURAL and give ne  |  |   |                   | c CITY OR TOWN                                      |                    | rote limits, write Rt           | JRAL and give n  | earest fown  | 1)                |
| d. NAME OF HOSPIT  | OITS AL (If not in hospital, give                            | street address)   | 5                 | d. STREET ADDRES                                    | raton<br>is        |                                 |                  | e. IS RES    | IDENCE            |
| OR INSTITUTION   | el General H   | <u>_</u>  | į                 | 3 4   | ookwood            | Road                            |                  | ON A         | FARM?             |
|  |  |   | 1                 | 7 - 7   |                    |                                 |                  |              |                   |
| 3. NAME OF<br>DECEASED   | First  | ^   | Widdle            | Last<br>TATE CETT                                   | 4. DATE<br>OF      | Mani                            |                  | /            | Year              |
| (Type or print)  | Edward   |   |                   | PERINA,   | Sr DEATH           | Jul                             | <u> </u>         |              | 1960              |
| S SEX  | 6 COLOR OR RACE 7  | MARRIED NEVER A   | AARRIED .         | B DATE OF BIRTH                                     | - 000              | 9. AGE (In years last birthday) | Months Days      |              | Min,              |
| Male   | White w  | DOWED KK DIV  | ORCED             | July 27,  | 1900               | 59 yrs                          |                  |              |                   |
| during most of work  | ON (Give kind of work done ing life, even if retired)        | 10b. KIND OF BUSIN  | NGH or            | Mary  | rland              | ountry)                         | 12 CITIZEN C     | .S.          | OUNTRY            |
| 13. FATHER'S NAME  | Han Ce   | rana  |                   | 14 MOTHER'S MAID                                    | EN NAME            | ichle                           |                  |              |                   |
|  | IN U.S. ARMED FORCES<br>If yes, give wer or dates of service |   | 17 NO 17, IN      | FORMANT COL   | und (              | Perma                           | "IR              |              |                   |
| Canditians, if a gave rise to it cous (a), stating lying cause last. | mmediate Dus To  | peri Peri   | etw<br>any<br>car | arte<br>do tim                                      | t fe               | ei lu<br>Virea                  | ~ · · ·          | ?<br>?<br>40 | DEATH             |
| DE 05  | ER SIGNIFICANT CONDITI                                       | here  | un                | mu  |                    |                                 | EN IN PART 1(0)  | PERFO        | AUTOPSY<br>ORMED? |
|  | CAUSE OF DEATH MEDICAL EXAMINER)                             | PESCRIBE HOW INJ  | JRY OCCURRED      | ), (Enter nature of injury                          | y in Part I or Par | r 11 our riem 16 }              |                  |              |                   |
| 20c TIME OF INJUR<br>Hour o.m.                                       | 10   | 20d. INJURY OCCURRE<br>While Not while<br>of work of work | fac               | ACE OF INJURY (Home,<br>tory, street, office bldg., |                    | or town)                        | (Count)          | r)           | (Stote            |
| 21 I certify tho   | t (I) (this haspital) a                                      | ittended the dece   | ased fram.        | July 2,   | 19 60 Lta          | July 5,                         | ., 19.60, 1      | that (!) (   | we) las           |
| saw the deceas   | ed alive an July   | 5-1-2060,   | and that d        | eath accurred at_                                   | M, fram            | the causes an                   | d an the dat     | te stated    | l abave           |
| 220 SIGNATURE  | and M.   | Ship  | le .              | ATTENDING DE  | OO A.M.            | STAFF<br>PHYS                   |                  |              | DATE<br>SIGNED    |
| 22c PHYSICIAN'S<br>NAME (Type)                                       |  |   |                   | 22d ADDRESS   |                    |                                 |                  |              |                   |
| (.,,,,,,,  | Frank M. Shi   | pley  | /                 | 121 Cath  | medral S           | t., Annar                       | olis, M          | d.           |                   |
| 23a BURHAL, CREMATIO<br>REMOVAL (Specific                            | N. 131 DATE THEREOF  | O 23c NAME OF   | CEMPTERY O        | CREMAJORY J   | 23d 198A           | UON (City Jown, o               | or county)       | ndo          | te)               |
| 24 FUNERAL DIRECTOR  | S SIGNATURE FUR  | de Der  | Bur               | ne hyd 25d.   | REC'D BY REGIS     |                                 | STRAR'S SIGNAT   |              |                   |



| d V  | 5      |
|--|--------|
| please<br>shou   | 1      |
| TO DEPLITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any pis necessary, please executed within 24 hours after death. If any pis necessary, please executed within 24 hours and 3 to the function. Page 4 should be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.  | 1      |
| f. P   | 2      |
| is n<br>ecto   | 5      |
|  | 2      |
| y duy  | 2      |
| O DEPLYTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any tripy is some certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the functional farwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. O FUNERAL DIRECTOR: Page 3 should be used as a buried-transit permit files.  |        |
| to fi  |        |
| nd 3<br>Peta 3   | d .    |
| 2, all   | /      |
| S J.   | 1      |
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| VS. A15ME  | (5)    |

5M 9/55

|                  | . 7646 MEDIC  | AL EXAMINER                                | S CERTIFICAT   | E OF                   | DEATH                           | Reg. Dist.     | 7619                  |
|------------------|---|--|--|------------------------|---------------------------------|----------------|-----------------------|
| 1, 19            | ACE OF DEATH  |  | 2. USUAŁ RESIDENCE (W  | /here decease          | d lived. If institu             |                |                       |
| 0.               | Anne Arundel  | MARYLAND                                   | o. STATE Maryl   | and                    | b. COUNT                        | 144/Add        | 114 -A-A-V            |
| b.               | CITY OR TOWN (If subside corporate limits, write EURAL and give nearest lown)   | c. LENGTH OF STAY IN 15                    | c. CITY OR TOWN (IF  |                        |                                 |                | e nearest town)       |
|                  | Glen Lurnie   | 10 hrs.                                    |  | /344dd                 | * Baltin                        | nore 45        |                       |
|                  | NAME OF HOSPITAL OR INSTITUTION (If not in  | ,  | d. STREET ADDRESS  |                        |                                 | . 1            | ON A FARM             |
|                  | 601 Sixth Ave and Ritc  |  |  | Street                 |                                 |                | YES NO                |
| (T               | ppe or print) Elmoden Pitcoc  |  | Last   | 4. DATE<br>OF<br>DEATH | July 18                         | th.            | ay Year<br>19 6       |
| 5. SE            |   | RRIED NEVER MARRIED   8                    | 3/28/14  |                        | 9. AGE (In years lost byrisday) | Months Days    |                       |
| lDa.<br>du       | USUAL OCCUPATION (Give kind of work done 10) ring most of working life, even if retired) I I ght watchinan                            | . KIND OF BUSINESS OR INDUS                | Winchester   | - 1                    | untry)                          | 12. CITIZEN    | OF WHAT COUNTE        |
| 13. F            | Elmoden FXX Pitcock   |  | 14. MOTHER'S MAIDEN N<br>Ldna Avery                          | IAME                   |                                 | -              |                       |
| 15. Y<br>(Yes, 4 | po, or unknown). 1. (if yes, give way or dates of service)  | // - /                                     | rs. Nora Pito  | ock                    | Address                         |                |                       |
|                  | 8. CAUSE OF DEATH [Enter only one cause per le  | ne for (o), (b), and (c).] Coronary Occlus | ion  |                        |                                 | 1500           | NET AND DEATH UGGON . |
|                  | Conditions, If ony, which gave rise to immediate cause (o), stating the underlying cause lost.  PART II. OTHER SIGNIFICANT CONDITIONS | CONTRIBUTING TO DEATH BUT I                | NOT RELATED TO THE TERMI                                     | NAL DISEASE            | CONDITION GIV                   | EN IN PART I(a | 19. WAS AUTOPS'       |
| CERTIFICATION    | 100. EXTERNAL CAUSE WAS 20b. DESCI  | RIBE HOW INJURY OCCURRED (I                | nter nature of Injury in Part                                | I or Part It a         | f item 18.)                     |                | PERFORMED?            |
| MEDICAL          | Hour o. m. W of   | hile Not while foct<br>work of work        | CE OF INJURY (Home, farm<br>ory, street, office bldg , etc.) |                        | or town)                        | (County)       | (State                |
|                  | 21. I certify that I taak charge of the death resulted fram: Natural causes   | Accident , Sui                             | ve, held an Autops)<br>cide [], Hamicide                     | _                      | spectian 🐴,<br>determined c     |                | 3, and find th        |
|                  | ACTUAL GUSTADE A La   | whendud'                                   | _M.D. CHIEF MEDICAL EX                                       | _                      | П                               |                | DATE SIGNED           |
|                  | EXAMINER'S Gustave H. Fauber  | rt.A.D.                                    | DEPUTY MEDICAL E   |                        |                                 | 0              |                       |
|                  | BURIAL CREMATION, 22b. DATE THEREOF 7/21/60   | 22c. NAME OF CEMETERY OR                   | CREMATORY<br>On Cemetery                                     |                        | ON (City, fown, o               | or county)     | (State)               |
|                  |   |  | V  | YI [ ]                 | CHESTAY                         | 7 7 GLa        |                       |
|                  | opping and Kirkley,   | Glen Burnic,                               |  | 8Y REGISTR             | AR 24b. REGIS                   | TRAR'S SIGNAT  | TURE                  |



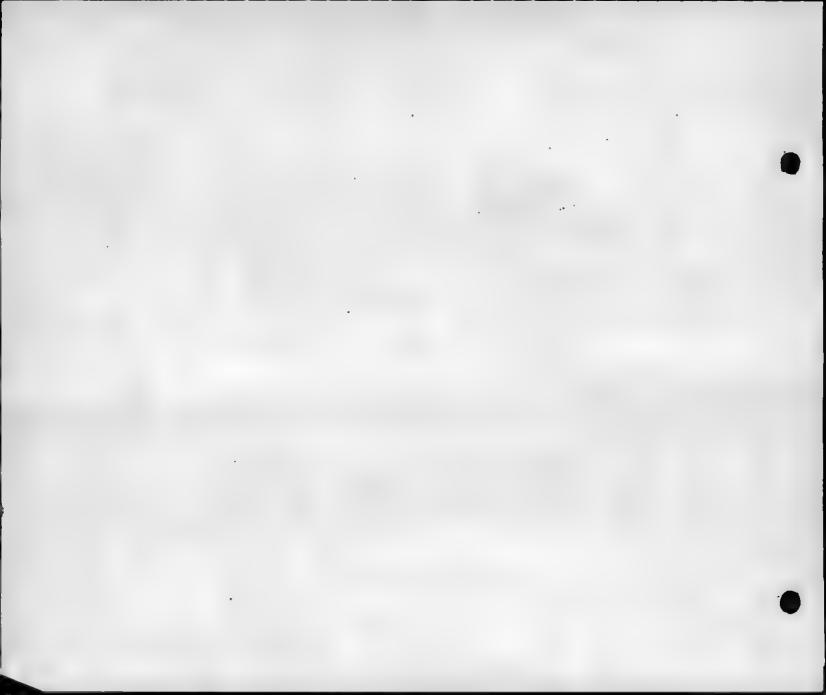
V\$. A15ME(5) 5M 9/55

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

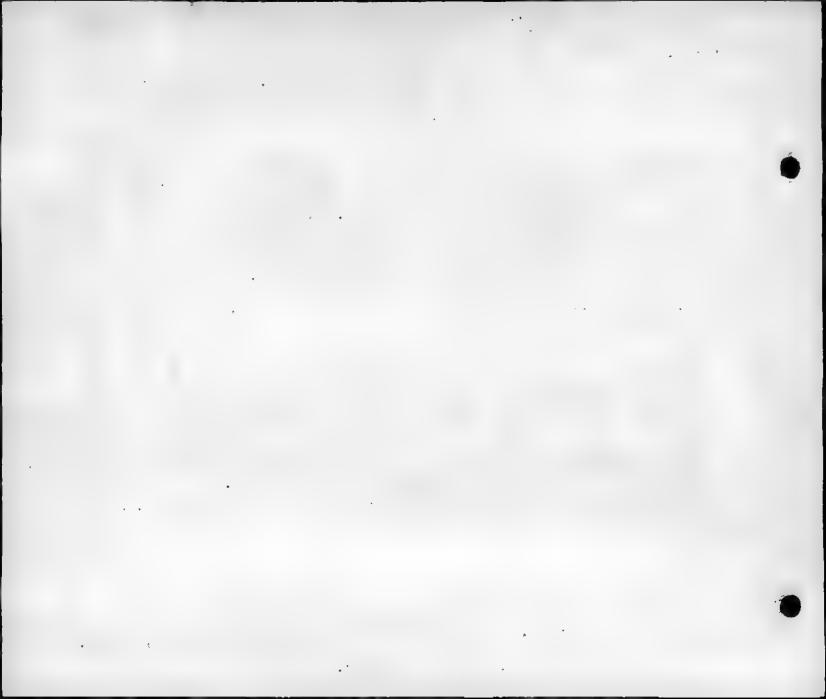
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|      | _   | r ~  | Con / | - |
|------|-----|------|-------|---|
| Reg. | Dis | t. 1 | No.   |   |

| 1,  | PLACE OF DEATH   |                        |                          |                           |                            | 2. USUAL RESIDENCE (\  | Where decad                                  |                    |            | nce befo            | ore admi  | ssion)  |
|---|--|------------------------|--------------------------|---------------------------|----------------------------|--|--|--------------------|------------|---------------------|-----------|---------|
|   | a. COUNTY Anne   | Arundle                |                          | MARYL                     | AND                        | o STATE Same   |  | b. COUNT           | Y Sa       | me                  |           |         |
| b. CITY OR TOWN (It outside corporate limits, write RURAL one give negretal form) |  |                        |                          |                           |                            | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) |  |                    |            |                     |           |         |
|   | Glen Eurn  |                        | Same &C                  |                           |                            |  |  |                    |            |                     |           |         |
| Г   | d. NAME OF HOSPITA   |                        | d. STREET ADDRESS (e. IS |                           |                            |  |  |                    | ESIDENCE   |                     |           |         |
| L   | 218 Vick   | low .ve.               |                          |                           |                            | Samo ON A FAR  |  |                    |            |                     |           |         |
| 3. NAME OF First DECEASED   |  |                        | Middle                   |                           | Lest 4. DATE Month         |  |  | 1                  | Day Year   |                     |           |         |
|   | (Type or print)  |                        |                          | Lee                       |                            | Pamsburg   | DEATH 7                                      |                    |            | 20 1960             |           | 960     |
| 5.  | SEX  |                        |                          | RRIED NEVER MARRIED       | ED NEVER MARRIED 8.        |  | DATE OF BIRTH 9. AGE (In year lost birthdgy) |                    |            | YEAR IF UNDER 24 HR |           |         |
|   | Female   |                        |                          | WED DIVORCED              | 3                          | 4/23/03 /8   | 92 7/ yrs. Months                            |                    | Days       | Hours               | Min.      |         |
| 10  | . USUAL OCCUPATIO  | N (Give kind of work   | done 10                  | 6. KIND OF BUSINESS OR IN | IDUSTR'                    | 11. BIRTHPLACE (State  | or foreign                                   | country)           | 12. CIT12  | EN OF               | WHAT      | COUNTRY |
|   | Tous 3 Wife  |                        | Louden Go., Virginia     |                           |                            |  |  | U.S.               |            |                     |           |         |
| 13  | . FATHER'S NAME  |                        | 14. MOTHER'S MAIDEN NAME |                           |                            |  |  |                    |            |                     |           |         |
|   | John Sc  | heefer                 |                          |                           |                            | Darcus Jane ?  |  |                    |            |                     |           |         |
| 15  | . WAS DECEASED EVE   | R IN U. S. ARMED FO    | RCES?                    | 16. SOCIAL SECURITY NO.   | 17. INI                    | ORMANT   | - C-0210 - 6                                 | Address            |            |                     |           |         |
| Į,  | [If yes, give war or dates of service)   |                        |                          | 'Jo                       | Mrs. Lucy Lahan (daughter) |  |  |                    | hom)       |                     |           |         |
| F   |  | H. [Fater only one col | ise per l                |                           | 11                         | rp. Ducy Da  | 1011   | 10 sugar           | 00± /      | INTER               | VAL BETWI | EEN     |
|   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED 8Y: Company Conditions   |                        |                          |                           |                            |  |  |                    |            | Sudden              |           |         |
|   | IMMEDIATE CAUSE (6) Coronary Occlusion   |                        |                          |                           |                            |  |  |                    |            | 1200                | gaen      |         |
|   | OUE TO   |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   | Conditions, if any, which (b) gove rise to immediate cause   |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   | (o), stoting the underlying OUE TO   |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
| _   | cause last. (c)  |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
| O N   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?                                |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
| 3   |  |                        |                          |                           |                            |  |  |                    |            | Y                   | ES 🗌      | МО 🔲    |
| CERTIFICATION   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II af item 18.)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II af item 18.) |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
| SE  | 20c. TIME OF NJUR  | Y Month, Day, Ye       | or 20                    | d. INJURY OCCURRED   20e  | PLACE                      | OF INJURY (Home, form  | n, 20f. (Cit                                 | y or town)         | (Cou       | nty)                |           | (State) |
| MEDICAL   | Hour a. m. While Nat while factory, street, office bldg., etc.)  |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
| 1   | 21. I certify that I taak charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find the   |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   | death resulted fram: Natural causes X, Accident , Suicide , Homicide , Undetermined cause .  |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   |  |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   | ACTUAL GUESLAND ME CHIEF MEDICAL EXAMINER []   |                        |                          |                           |                            |  |  |                    |            | DATE SIGNED         |           |         |
|   | ASSISTANT MEDICAL EXAMINER   |                        |                          |                           |                            |  |  |                    |            |                     |           |         |
|   | NAME (Type) Gustave H. Faubort M. D. DEPUTY MEDICAL EXAMINER D   |                        |                          |                           |                            |  |  |                    |            | 7/20/60             |           |         |
| 22  | BURIAL, CREMATIO   | N, 226. DATE THEREC    | )F                       | 22c. NAME OF CEMETER      |                            |  | 22d. LOCA                                    | ATION (City, town, | or county) |                     | (Stat     |         |
|   | REMOVAL Specify)   | 7-23                   | -60                      | Nin Ca                    | the                        | Like Com,  | 633  | 2071000            | 2 2        | 179                 | 0         |         |
| 23  | FUNERAL DIRECTOR'S   | SIGNATURE              |                          | ADDRESS                   |                            | 24a. REC   | D BY REGIS                                   | TRAR 24b. REGI     |            |                     |           |         |
|   | , ",   | 62 7 100               | 1                        | ADDRESS                   | 12 1                       | DATE DATE  | 1 22 1                                       | ىن ئار             | alma S. i  | Tirau               | d.        |         |

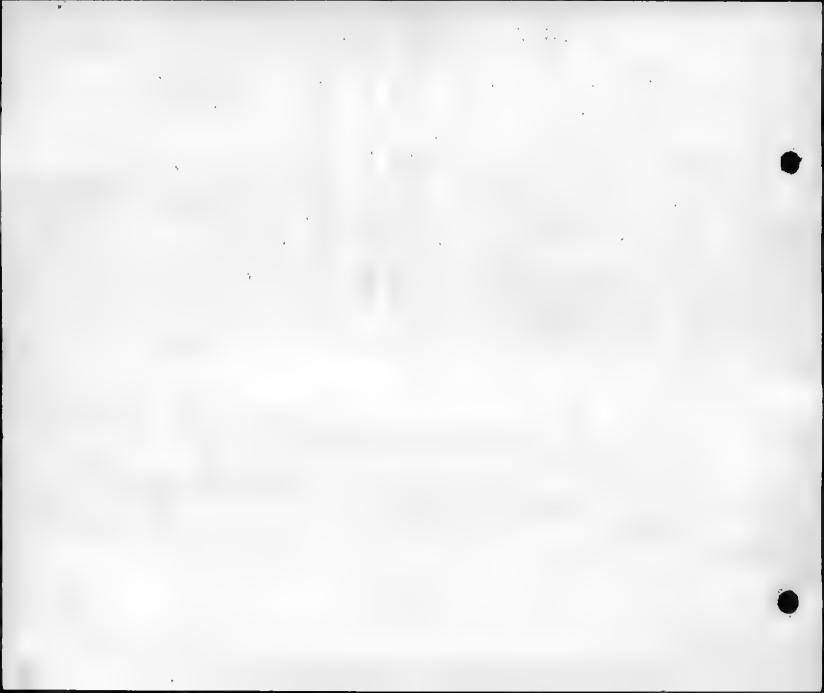


| FOR STATE  |  |  |   |   |   | ALTH—BALTI  | EATH                               | 0762<br>Dist. No.         | 1             |  |  |
|--|--|--|---|---|---|---|------------------------------------|---------------------------|---------------|--|--|
| B &  | 1. PLACE OF DEAT   | Anne Arund   | el  | MARYLAND  | 2. USUAL RESID  | ENCE (Where deceased li   | ved If institution: Reb. COUNTY AA | ridence before oc         | imission)     |  |  |
| Hed Fig.   | und give neares  | (N (if cuttude corporate limits, write (jown)  |   | IGTH OF STAY IN TO  |   |   |                                    |                           |               |  |  |
| e Boord  | d. NAME OF HO  | DSP TAL OR INSTITUTION (   | f not in hospital, gi   | n hospital, give street oddress)                          |   | d, STREET ADDRESS   |                                    |                           | ON A FARM?    |  |  |
| the State of the S | 3. NAME OF<br>DECEASED<br>(Type or print)  | Joh  | n   | Middle<br>David   | Rice  | 4. DATE<br>OF<br>DEATH  | Month<br>July                      | 27                        | Year<br>19 60 |  |  |
| ours of  | Male   | White  | WIDOWED [   |   | Tan. 18,  | 1914 4  | 6 yrs. Month                       | Doys Hour                 |               |  |  |
| Boge I and him 72 h  | Mechan   | PATION (Give kind of work orking life, even if retired)  C   | US GC   |   | Maby.   | E (State or foreign count)<br>Land  | γ) 12.                             | USA                       | AT COUNTRY    |  |  |
| Ma. Wall   | 13. FATHER'S NAM   |  | Dian  |   | 14. MOTHER'S M.   |   | 9 3                                |                           |               |  |  |
| Give Po  | W11  15. WAS DECEASE (Yes, no, or enknown)  NO   | D EVER IN U. S. ARMED FO   | RCES? 16. SOCIAL  |   | FORMANT   | era F. Don<br>le Rice, S  | Address                            |                           |               |  |  |
| in pencif in hem 18. wher's Office along we a burial-transit permits, ar removal, and in   | Conditions.  | DEATH (Enter only one cold DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o) DUE TO only, which mediate couse the undertying OUE TO (c) | Suici   |   | ntary in  | halation of   | carbon                             | Interval Bet<br>Onset and | den           |  |  |
| ting the ward "pending<br>the Chief Medical Exa<br>ige 3 shauld be used as<br>rior ta buriat, cremati  | 20g. EXTERNAL PRIMARY-D of CAUSE OF DE. TO CAU | NJURY Month, Day, Yes  | By cot  The state of the state | INJURY OCCURRED (E. nnecting on occurred foctor while Hog | nter nature of injure of end of the privilety (Horry, street, office black) | y in Post tor Port II of the rubber hose police. The Active of the Miller | to sympa;                          | YES County)               | t pipe        |  |  |
| 4 shauld be forwarded to 70 FUNERAL DIRECTOR: Pa or its designated agent, p  | 21. I certify that I tack charge of the remains described above, held an Autopsy   , Inspection   A. Inquiry   A. ond in my opinion death resulted from: Natural causes   , Accident   , Suicide   A. Hamicide   , Undetermined manner   ACTUAL SIGNATURE   ACTUAL SIGNATURE   ASSISTANT MEDICAL EXAMINER   ASSISTANT MEDICAL EXAMINER   TO ASSISTANT MEDICAL  |  |   |   |   |   |                                    |                           |               |  |  |
| 6. A15ME   | 23. FUNERAL DIRECT   | and Kirkle   | Y/VCTOV 1   | Burnie,   |   | o. REC'D BY REGISTRAR ATE JUL 2 9 '60                                     | 246, REGISTRAR'S                   | Stenature .               | 144           |  |  |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH



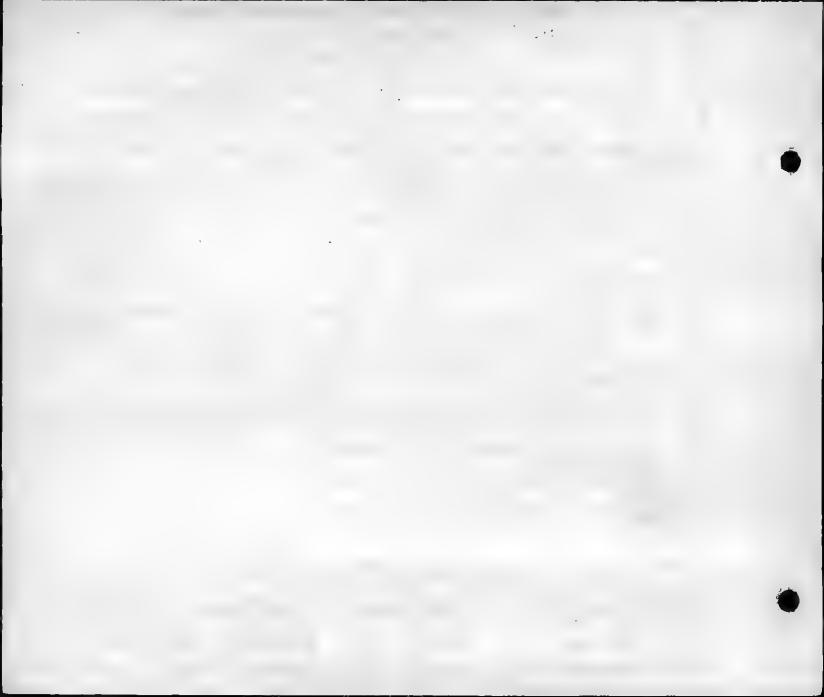
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

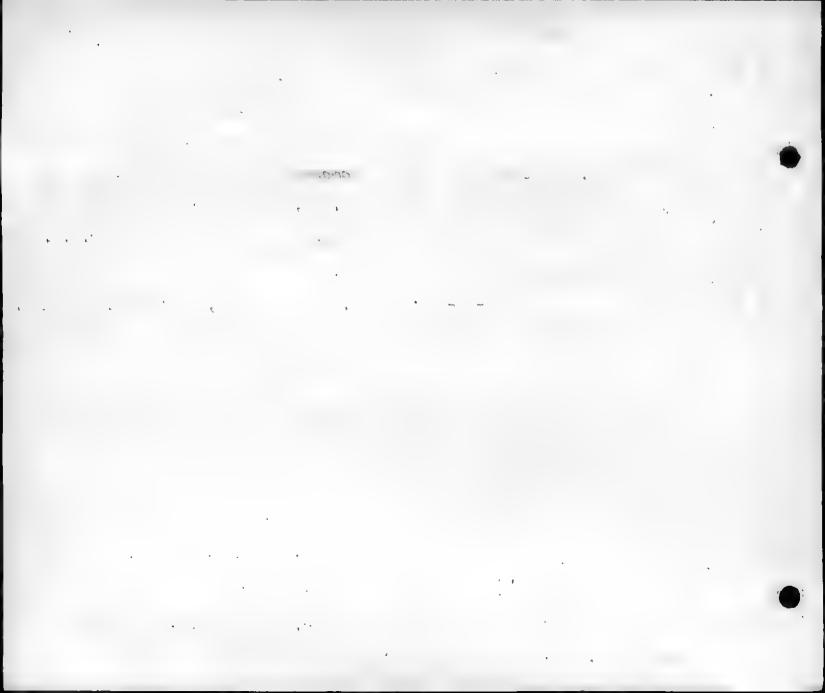


Offi O



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18





7606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH a COUNTY. D. STATE MARYLAND CITY OR TOWN III outside of c. LENGTH OF STAY IN 16 OR INSTITUTION If not in hospital give street address) d. STREET ADDRESS NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED 8. DATE OF BIR WIDOWED [ DIVORCED 100 USUAL OCCUPATION (Give k'paker work dode 10b, KIND OF BUSINESS OR INDUSTRY during most of warking life, lever if jetired) 13. FATHER'S NAME WAR MO. 960 EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN 18. CAUSE OF DEATH | Enter only one cause per line fer (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gave rise to immediate cause **DUE TO** (a), stoting the underlying couse lost. PART II. OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NALDISEASE CONDITION GIVEN IN PART 1(0) 19 WAS ALTOPSY CATION 20o. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. Month, Day, Year 20e. PLACE OF INJURY (Home, form, 120f. (City or fown) 20c. TIME OF INJURY 20d INJURY OCCURRED factory, street, office bldg , etc.) Hour Not while a. m. at work at work p. m. 21. I certify that I took charge of the remains described above, held an Autopsy [ death resulted from Natural cáuses 🕖 Accident | Suicide | Hamicide ACTUAL CHIEF MEDICAL EXAMINER 00 EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER 220. BURIAL, GREMATION, 226. DATE THEREOF 22c. NAME OF COMETERY OR CREMATORY 0 20) FUNERAL DIRECTOR'S SIGNATURE ARDRESS 24a, REC'D BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. NO 7627 2. USUAL RESIDENCE (Where deceased lived. If Institution: Rendence before adaptission) b. COUNTY c. CITY OR JOWN of outside corporate limits, write RURAL and give nearest town) e IS RESIDENCE ON AFARM? YES NO 4. DATE Month Year OF 190 IF UNDER TYEAR 9. AGE I'M IF UNDER 24 HRS Months Days Min. yes. OF WHAT COUNTRY? 12. CITIZEN SCONS/A INVERVAL LETWEEN GINSET AND DEATH PERFORMED? YES T (Stote) (County) Inspection ... Inquiry and find that Undetermined cause DATE SIGNED ASSISTANT MEDICAL EXAMINER

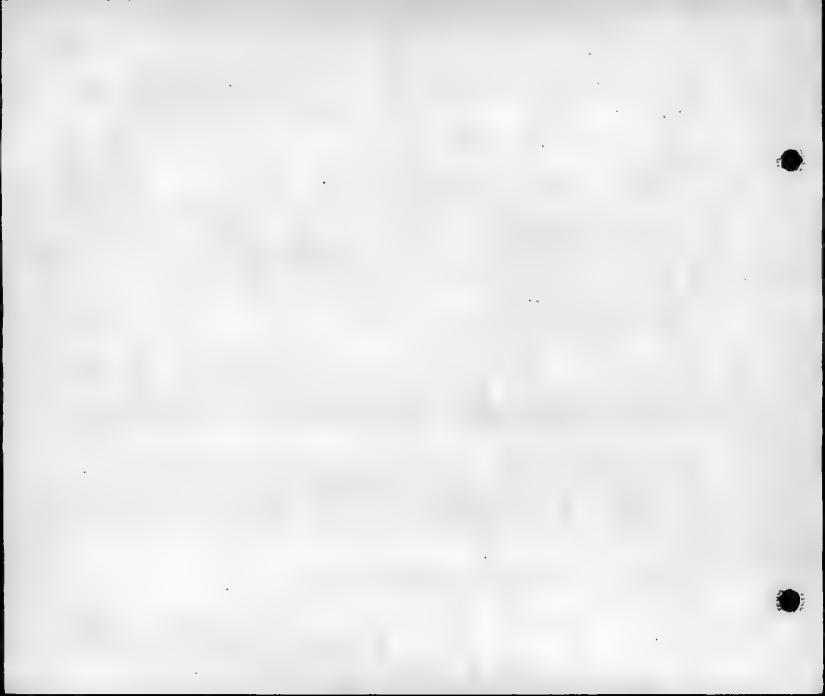
22d COCATION (City, lown, og county)

DATE 111 1 2 '60

245. REGISTRAE'S SIGNATURE

Circling S. Kenses

VS. A15ME(5) 5M 9/55



TO MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the death; Page 4 may lained by the haspital or attending physician.

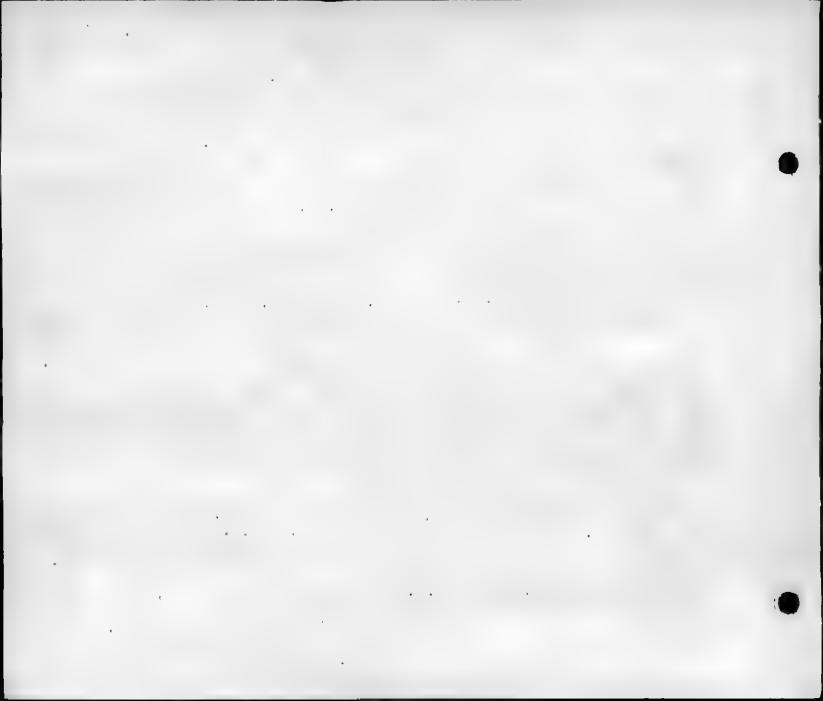
TO FUNEXAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, crematian, ar remayal, and in any event within 72 hours offer death. H MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7653 CERTIFICATE OF DEATH

Reg. Dist. ND 7628

| 1.            | PLACE OF DEATH o. COUNTY Anne   | Arunael  |                  |                | MARYL          | AND             | 2. USUAL RES<br>o. STATE | Md .                          |                       |                             | nstitutio           | n Residenc | e befo         | re admissi | on)                      |
|---------------|---|--|------------------|----------------|----------------|-----------------|--------------------------|-------------------------------|-----------------------|-----------------------------|---------------------|------------|----------------|------------|--------------------------|
|               | B. CITY OR TOWN (IF   | outside corporate limitarest town) UNNIE       | ts, write        | c. LENGTH      | OF STAY II     |                 |                          | Glen                          | _ `                   |                             | write RL            | JRAL ond g | ive neo        | irest lown | )                        |
|               | d. NAME OF HOSPITA<br>OR INSTITUTION<br>902 CT  | u (If not in hospitol, grain High              |                  | oddress)<br>NW | /              |                 | d. STREET                |                               |                       |                             | NW                  |            |                |            | DENCE<br>FARM?<br>NO 13- |
| 3.            | NAME OF<br>DECEASED   | Fir  |                  |                | Middle         |                 | Lo                       |                               | 4. DATE               |                             | Mont                | h          | Do             | у Ү        | eor                      |
|               | (Type or print)   | Mami   |                  | Augi           |                |                 | Rub                      | у                             | DEATH                 |                             | Jul                 | У          | 7              | 1          | 960                      |
| S             | SEX<br>F  | 6. COLOR OR RACE                               | 7. MARI<br>WIDOW |                | ER MARRIED     |                 | Mar.                     | н<br>3,189                    | 94                    | 9. AGE (In<br>lost bigth    | iday)               | Months     | 1 YEAR<br>Doys | Hours      | R 24 HRS<br>Min          |
| 10            | during most of works HOUSEW   | N (Give kind of work on life, even if refired  | done 10b         |                | SINESS OR Home | INDUS           |                          | Ltimo                         |                       |                             | v                   | Į.         | ZEN O          |            | COUNTRY                  |
| 13.           | FATHER'S NAME   |  |                  |                |                |                 | 14 MOTHER'S              |                               | -                     |                             | ,                   |            | 0222           |            |                          |
|               | Theo  | dore Met                                       | zke              |                |                |                 |                          | Paul                          | Line                  | Dalhl                       | 92                  |            |                |            |                          |
| 1S.           | WAS DECEASED EVER   | IN U. S. ARMED FOR                             |                  | SOCIAL SEC     | URITY NO.      | 17. 1F          | FORMANT                  |                               |                       |                             | Addr                | 011        |                |            |                          |
| Ĺ             | no  | none   |                  |                | d the Street   | Mr              | . Will                   | iam W                         | V. Ru                 | iby, s                      | sam                 | e as       | 2              |            |                          |
|               | 18 CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c)]  PART I DEATH WAS CAUSED BY:  Myocardial Infarction  ONSET AND DEATH  ONSET AND DEATH |  |                  |                |                |                 |                          |                               |                       |                             |                     |            |                |            |                          |
|               | Conditions, if on   |  |                  | Core           | nary           | Ar              | tery D                   | )iseas                        | s e                   |                             |                     |            |                | 2-3        | у.                       |
|               | gove rise to im<br>couse (a), stating the<br>lying couse lost   |  |                  | Нур            | reten          | siv             | e Hear                   | t Dis                         | sease                 |                             |                     |            |                |            |                          |
| CERTIFICATION | PART II. OTHE   | ER SIGNIFICANT CON                             | DITIONS (        | ONTRIBUTION    | IG TO DEAT     | H BUT           | NOT RELATED TO           | O THE TERMIN                  | NAL DISEAS            | E CONDITIC                  | N GIVI              | EN IN PART | 1(0) 1         | PERFO      | UTOPSY<br>RMED?          |
|               | 200 ACCIDENT WAS<br>OR CONTRIBUTING OF<br>(IF EITHER, NOTIFY A  | UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES         | CRIBE HOW      | NJURY OC       | CURRED          | (Enlar noture o          | of injury in P                | ort 1 or Par          | rt 11 of item 1             | IB.)                |            |                |            |                          |
| MEDICAL       | 20c TIME OF INJURY<br>Hour o.m.   | Month, Doy, Yes                                | While            | NOT WE DE      | ile            | Oe. PLA<br>foci | CE OF INJURY I           | Home, form,<br>e bldg., etc j | 20f (Cit)             | y or town)                  | -                   | (C         | ounty)         |            | (Stote)                  |
|               | 21. I certify the   | at 1 attended the                              | deceas           | ed from _      | 7.5.           |                 | 1960                     | ) to 7                        | 7.7.6                 | 0. 1                        | 9                   | that I le  | ast so         | w the      | decenser                 |
|               | alive on7   | Level &  | , 12_(           | A. 1           | nd that d      | leath           | occurred at              | 10.00                         | DMPfrdY<br>ADDRESS (S | methe cau<br>treet, city or | isës (ii<br>Iown, i | nd an th   | e dai          | e state    | d above                  |
|               | SIGNATURE   |  |                  | 0              | *              | ^               | (.D                      | Larn                          | urgi                  | iway (                      | J 1 C               | 1 15(4)    |                | e , me     |                          |
|               |   | Andrew K                                       |                  |                |                |                 |                          | Crain                         |                       |                             |                     |            | n i            | Burr       | ie                       |
| L             | BURIAL CREMATION  | 7/12/6   | 0                | Gler           | Hav            | en,             | Memori                   |                               |                       | n Bu                        |                     |            | i.             | (Stole     | }                        |
|               | FUNERAL DIRECTOR'S Hopping a  |  | - / -            | Glen           | 1000           |                 | Md.                      | 240. REC'D                    |                       |                             |                     | TRARS SIG  |                | E          |                          |
|               |   |  |                  |                |                |                 |                          |                               |                       |                             |                     |            |                |            |                          |

VS A15 (4) 15M 9/SS



| 1.     | d. COUNTY  | 1 /                                       |                   | o. STATE   | b. CO                    |                        | etore admission)   |
|--------|--|---|-------------------|--|--------------------------|------------------------|--|
| L      | Anne Hy  | vud e/                                    | MARYLAND          | 17254/2  | 2.6                      |                        |  |
| L      | b CITY OR TOWN (If outside corporate<br>RURAL and give nearest town)   | limits, write c. LENGTH C                 | DE STAY IN 16     | c CITY OR TOWN (If outsi                                       | de corporate limits, w   | rite RURAL and give    | nearest town]  |
|        | . Yallers vill   | 0 2 w                                     | ·ceks             | Bal Tim  | 67-e                     |                        | 1 4  |
|        | OR INSTITUTION A haspi   | al give street address)                   |                   | d STREET ADDRESS   |                          |                        | e IS RESIDENCE<br>ON A FARM?   |
| 1      | Milliord /   | u amor "                                  |                   | 1445 Az  | dage 9                   | 1, 1                   | YES NO   |
| 3.     | NAME OF  | First                                     | Middle /          | 1 lost 1 4.  | DATE                     | Months /               | Day / Yeor   |
|        | (Type or print)  | 4   | 10%               | nudet  | OF DEATH                 | 1/6/                   | 600  |
| 5      | SEX // 6 COLOR OR BU   | MARRIED NEVER                             | NA PRIED TO IR I  | DATE OF BIRTH  | 9 AGE (In                | egrs IF UNDER 1 YE     | AR IF UNDER 24 HRS   |
| ľ      | 11/200 10/1  | -   | . HOTHER .        | wech 18-180  | 9 AGE (In lost birth     |                        | s Hours Min.   |
| 1      | Mac VIII   |   | MAOKCES []        |  | 74                       | yrs III CITIZEN        | OF WHAT COUNTRY?   |
| 1,,    | 00 USUAL OCCUPATION (Give kind at we<br>during most of working life, even if re  | hired) the KIND OF BUS                    | INESS OK INDUSTRI | T II BIKIMPLACE (Side or I                                     |                          |                        | OF WHATCOUNIKE   |
| L      | Bigger dearpe  | nter -                                    |                   | 5  | CIMAI                    | by                     | 11. 7.11.  |
| 13     | 3. FATHER'S NAME   |   | 1                 | 14. MOTHER'S MAIDEN NAM  | IE .                     |                        |  |
| Г      | Un   | Known                                     |                   |  | Un Kn                    | 042                    |  |
| 15     | S. WAS DECEASED EVER IN U. S. ARMED  |   | RITY NO 17 INFO   | RMANT  |                          | Address                |  |
|        | No   | 215-07-                                   | 4155 AW           | Posta Schni  | dT 144                   | 5 Ands                 | e 5T.  |
| F      | 18 CAUSE OF DEATH   Enter only or  | ne cause per line for (o), JUX            | and King          |  | 7/1/                     | <u> </u>               | NTERVAL BETWEEN  |
|        | PART I DEATH WAS CAUSED IMMEDIATE CAU  | BY. Onely                                 | RITT              | ugancip  | 110X1 C                  | ma.                    | 160014   |
|        | 1 1 2 1 0  | JE TO 15                                  | 3/                | 111 +  |                          |                        |  |
|        | Conditions, if any, which )  | MINICHI                                   | - Meb             | Klowley_   | ,                        |                        | 2- Zakes   |
|        | The same of the sa | 210                                       | 4/                | 10 00  |                          |                        |  |
|        | lying couse lost.  | a NICAL                                   | land.             | foreal h   | 1000                     |                        |  |
| 2      | PART II OTHER SIGNIFICANT  | COMPITIONS CONTRIBUTION                   | TO SPETH BUT NO   | TO DELATED TO BUT TEDALORS                                     | LOSEASE CONDITIO         | NI CHVENI INI PART 1/a | I 10 WAS ALITOPSY  |
| E G    |  | Le la | 11000             | PILL )   | POSLASE CONDING          | TO OTTER BATTAKE INC   | PERFORMED?   |
| E17.13 | Juves  | 1   |                   | The contract of  |                          | A 3                    | YES NO   |
| CEPT   | OR CONTRIBUTING CAUSE OF DE  | ATH                                       | ATORY OCCURRED (  | Enter noture of injury in Part                                 | I I or Port II of Item I | ы                      |  |
| 1      |  |   |                   |  |                          |                        |  |
| 1      | 20c TIME OF INJURY Month, Day,   |   | factor            | E OF INJURY (Home, form, ):<br>y, street, office blog, etc.) ! | 20F (City or town)       | (Coun                  | ity) (Stote)   |
| AAF    | р. п   | 19 While Not whi                          |                   | ala li   | : 1                      | 11/1/                  |  |
|        | 21 I certify that (1) (this has  | oital) altended the dec                   | eased fram        | 1/2/6019   | . 10                     | 0/06                   | that (I) (we) last   |
| L      | saw the deceased alive an_   | 07 11 h. 1/2-                             | ondethat dea      | ith accurred of 3 A  | from the cause           |                        | ate stated above   |
| ı      | 224 SIGNATURE  | 1/0/                                      | -201              |  |                          | _                      | 22b DATE:  |
| L      | 11182111   | Kalto                                     | KUG ME            | ATTENDING MED  | TOR STAFF                | 7                      | 16/60  |
|        | THE PHYSICIAN'S  | 1.7.1                                     | 1100              | 22d ADDRESS  | A 1- 1                   | 1- 6                   | 2/   |
|        | NAME (Type) LSUSE  | EP14 L/                                   | PSILE,            | y Ol   | DENTOI                   | a m                    | 1) 4   |
| 2      | BURIAL CREMATION, 236 DATE TH  | EREOF 23c NAME                            | OF CEMETERY OF    | REMATORY 23  | d LOCATION (City,        | lown, or county!       | (Stote)  |
| 1      | REMOVAL (Specify)  |   |                   |  | n n                      | , ,                    | 12/  |
| 2      | 4 FUNERAL DIRECTOR'S SIGNATURE   | 9-60 6/e<br>ADDRES                        |                   |  | Y REG STRAR 2Sb          | REGISTRAR'S SIGNA      | TURE   |
| 1      | Thatles L STEVE  |   |                   | T AVE DATE JUL   |                          | Couching S. Hu         |  |
| 1      |  | - 130                                     | 16.100            | / // YI DATE JUL.  | 1 0 00                   | Lusthan A. 74          | AND THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO I |

TO HOSE Land by the haspital or attending physician may the feath certificate be executed within 2. Its after death Page 4 may the samed by the haspital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or remaval, and in any event, within 2 haurs offer death

VR A1S (4) 1SM 9/59



VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7655

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 3()

| 1. PLACE OF DEATH o. COUNTY             | Arujaal   | MARYI   | n. STATE   | IDENCE (Where decease                     | d lived. If institution:<br>b. COUNTY | Residence before admission)         |
|---|---|---|--|---|---------------------------------------|-------------------------------------|
|   | f outside corporate limits                              | , write   c. LENGTH OF STAY I                       |  |   | orate limits, write RUR               | As and give nearest town)           |
| Pasade-                                 |   | 275   | Pasade   | 220_                                      |                                       |                                     |
| d NAME OF HOSPIT<br>OR INSTITUTION      | AL (If nat in hospital, gr                              | re street address                                   | d. STREET  | ADDRESS                                   | 1 4 11                                | e IS RESIDENCE<br>ON A FARM?        |
| Rt. 1-130x 25                           | 4B-Hunter   | 's Harbor   | 1/Rt-)-T   | 30x 254 B                                 | Hunters Ha                            | FOOF YES NO D                       |
| 3. NAME OF<br>DECEASED                  | First   | Middle  | La C C C C C   | OF  | Month                                 | Day Year                            |
| (Type or print)                         | Naomi   |   | SCOT   | pan .                                     | July                                  | 19 )                                |
| s. sex                                  |   | 7. MARRIED NEVER MARRIE WIDOWED TO DIVORCED         |  | гн<br>. <i>1911</i>                       |                                       | Months Days Hours Min               |
| 10a. USUAL OCCUPATIO                    | IN (Give kind of work di                                | one 10b. KIND OF BUSINESS OF                        | - / - J - p .  | LACE (State or fareign o                  |                                       | 12 CITIZEN OF WHAT COUNTRY?         |
| during most of world                    | the life, even if retired)                              | Murbhy's 5-1  | £57. 13.   | Ho. Md.                                   |                                       | U.S.A-                              |
| 13. FATHER'S NAME                       |   |   | 14. MOTHER"  | S MAIDEN NAME                             | 1                                     |                                     |
| Herry                                   | Curray  |   | Box  | tha Cut                                   | ( היישחד                              |                                     |
| S WAS DECEASED FOR                      | R IN U. S. ARMED FORCE                                  | ES? 16. SOCIAL SECURITY NO                          | INFORMANT  | 1.100 10011                               | Address                               |                                     |
| Yes, no. or unknown)                    | If yes give wor or dates of ser                         | 2/201-3345  | Mr. Wm.  | F. Scott, Ji                              | · Sam                                 | e As Fiz                            |
| 18 CAUSE OF DEA                         | TH [Enter only one cou                                  | se per line far (a), (b), and (c) ]                 |  |   |                                       | INTERVAL BETWEEN<br>ONSET AND DEATH |
| PART I. DEA                             | TH WAS CAUSED BY: IMMEDIATE CAUSE (o)                   | Unemin  |  |   |                                       | 5 10 T.3                            |
| 757                                     | DUE TO  |   |  |   |                                       |                                     |
| Conditions, if a                        | ny, which )   | Polycysti.  | kiuneys.   | . pilaters                                | t L                                   | Jonsenita                           |
| gove rise to i                          | mmediate (  |   |  |   |                                       |                                     |
| couse (a), stating                      | the <u>under-</u> (c).                                  | Mynonplit   | i g  |   |                                       | 6 mo.                               |
| Z PART II OTH                           |   |   |  | O THE TERMINAL DISEAS                     | E CONDITION GIVEN                     | IN PART I(o) 19. WAS AUTOPSY        |
| PART II OTH                             |   |   | Management of the Control of the Con |   |                                       | PERFORMED?                          |
| 20g ACCIDENT WAS OR CONTRIBUTING        | S UNDERLYING [ 2<br>CAUSE OF DEATH<br>MEDICAL EXAMINER) | 06 DESCRIBE HOW INJURY OC                           | CCURRED. (Enter noture   | of injury in Port I or Por                | t II of item 18 )                     |                                     |
| ZOc TIME OF INJUR<br>Hour a.m.<br>p. m. | Y Month, Doy, Year                                      | 20d INJURY OCCURRED While Not while al work at work | 20e. PLACE OF INJURY<br>foctory, street, office  | (Home, form, 20f (City<br>te bldg., etc.) | r or lawn)                            | (County) (State)                    |
| 21. I certify th                        | at lattended the  | deceased from 🗔                                     | , 19 🔍   | ), to 5 1 7                               | 19 July                               | at I last saw the deceased          |
| alive on                                | 12  | , 19 010 , and that                                 |  | _   |                                       | on the date stated above            |
|   | Laboreti.   | X / /1  |  |   | treet, city or town, sto              |                                     |
| ACTUAL<br>SIGNATURE                     | 1 Julius  | of Coll   | M.D  | Severna I                                 | Park. Mar                             | 2712nd 7-13-6                       |
| BUYETELANIE                             | Francis I   | . Jold  |  |   |                                       | . 7                                 |
| 220. BUR AL, CREMATIO                   | N, 22b. DATE THEREOF                                    | 22c. NAME OF CEME                                   | TERY OR CREMATORY  | 22d LOCA                                  | TION (City, lawn, or                  | caunty) (State)                     |
| REMOVAL (Specify)                       | 1-21-1  | 1960 Glen Ha  | MM   | Gle                                       | n Barri                               | p. 141.                             |
| 23. FUNERAL DIRECTOR                    | S. SIGNATURE  | ADDRESS   | 1 24 /   | 24a REC'D BY REGIS                        | TRAR 24b. REGISTR                     | RAK'S SIGNATURE                     |
| 7 Keter                                 | aleton  | Glen lau  | -12/2142   | DATE 111 1 8 '6                           | O Circles                             | of & Kenes                          |
|   | ,   |   |  |   |                                       |                                     |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7656 **CERTIFICATE OF DEATH** Reg. Dist NZ 631 filed with o. COUNTY 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY MARYLAND funeral b. CITY OR TOWN (If outside carparole fimits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write BURAL and give negrest town) RURAL and give nearest town) should mos. d NAME/OF HOSPITAL (If mo) in hospital, give street address) STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 12136 YES NO [ NAME OF 4. DATE Middle Month Year Doy DECEASED (Type or print) DEATH 1960 5 SEX & COLOR OR RACE 9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS 7, MARRIED NEVER MARRIED B DATE OF BIRTH Manths Days Hours DIVORCED [7] WIDOWED 1 popers. 0 Ars. compl 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN, OF WHAT COUNTRY? during most of working life, even if retired) puo carbon 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME physicion 17 INFORMANT ARMED FORCES? 16 SOCIAL SECURITY NO Address Emre ils attending 18. CAUSE OF DEATH / Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ā ONSET AND DEATH PART I. DEATH WAS CAUSED BY à permit. Conditions, if any, which peen signed gave rise to immediate cause (a), slating the underlying couse last. burial-transit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) removal. PERFORMED? YES NO 20d. ACCIDENT WAS UNDERLYING []
OR CONTRIBUTING [] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I ar Part II af item 18.) certificate 20c. TIME OF HYJURY Month, Day, Year 20d. INJURY OCCURRED-20e PLACE OF INJURY (Home, form, 20f. (City or Town) (Slate) factory, street, office bldg., etc.) Hour o.m. While Not while p. m. at work of wark 21. I certify that I attended the deceased from to 19222, that I lost sow the deceased detached alive on 60 and that death accurred at M, fram the couses and on the date stated above DIRECTOR: ADDRESS (Street, city or town, state) **DATE SIGNED** ACTUAL SIGNATURE should PHYSICIAN'S NAME (Type) FUNE 220 BURYAL CREMATION. 22b DATE THEREOF 22d LOCATION (City, fown, or county) 22c NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify) h 10 FUNERAL DIRECTOR'S SIGNATURE ADDRESS JUL 5 246. REGISTRAR'S SIGNATURE VS A15 (4) DATE 15M 10/57

Page

ofter death.

that the death certificate



VR AIS (4) 15M 9/59

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

07632

|     | No.           | 7   | 507  |           | CERTII                            | FICA     | TE OF DEA  | TH                     |  |                   | 0                | 763                | 32                    |
|-----|---------------|---|--|-----------|-----------------------------------|----------|--|------------------------|--|-------------------|------------------|--------------------|-----------------------|
|     | 4             |   | Anne Arund   |           | MAR                               | YLAND    | 2. USUAL RESIDENCE<br>o. STATE<br>Mar            | E (Where decease yland | ed lived If institut<br>b. COUNTY      |                   |                  | re odm ss<br>indel |                       |
|     | l             | CITY OR TOWN (IF RURAL and give nea                                       | prest lown)  | ts, write | 3 wks.                            | IN 1b    | 1  | N (If outside corp     | porote limits, write R                 | URAL ond          | g've ned         | rest town          | 1)                    |
|     |               | OR NSTITUTION   |  |           |                                   |          | d STREET ADDRE                                   | rthwest                | St.,                                   |                   |                  |                    | IDENCE<br>FARM?<br>NO |
|     | 1             | NAME OF<br>DECEASED<br>(Type or print)                                    | Marie  |           | Middle                            | =        | SIMMS  | 4 DATE<br>OF<br>DEATI  | Mor<br>Jul                             |                   | Do               |                    | Yeor<br>19 <b>60</b>  |
|     | 5 S           | emale   | 6 COLOR OR RACE Negro                                    | 7 MARE    | RIED NEVER MARR                   |          | B. DATE OF BIRTH                                 | 897                    | 9. AGE (in years tost birthday) 63 yrs | IF UNDE<br>Months | R 1 YEAR<br>Doys | Hours              | R 24 HRS<br>Min.      |
| 1   | 10a           | . USUAL OCCUPATION during most of working Dome still                      | N (Give kind of work in<br>ng life, even if retired<br>C | done 10b. | KIND OF BUSINESS (                | OR INDUS | TRY 11. SIRTHPLACE                               | (State or foreign      | country)                               | 12 CH             | TIZEN OF         |                    | OUNTRY?               |
| _ / | 13.           | FATHER'S NAME<br>George   | Clark  | ,         |                                   |          | 14. MOTHER'S MAI                                 |                        |  |                   |                  |                    |                       |
|     | 1S.<br>[Yes   | WAS DECEASED EVER   | IN U. S. ARMED FOR<br>Fyes, give wer or dotes of s       |           | SOCIAL SECURITY NO                |          | FORMANT<br>lorence Be                            | nson- Se               | Add<br>everna Par                      |                   | O. 14            | id.                |                       |
| ·   | TION          | Conditions, if on gave rise to im cause (a), stating It lying couse lost. | mediate DUE TO   | Can       | CHOMICONTRIBUTING TO DE           | 2,       | Sight NOT RELATED TO THE                         | LIMITERMINAL DISER     | A CONDITION GIVE                       | VEN IN PA         | RT 1(a) 1        |                    | AUTOPSY<br>PRMED?     |
|     | CERTIFICATION | 200 ACCIDENT WAS<br>OR CONTRIBUTING I<br>(IF EITHER, NOTIFY A             | CAUSE OF DEATH   | 206, DES  | CRIBE HOW INJURY O                | OCCURRED | Enter nature of inju                             | ory in Part I at Pa    | art II of dem 18 }                     |                   |                  | YES.               | NO 🗌                  |
|     | MEDICAL       | 20c. TIME OF INJURY<br>Haur a m<br>p. m.                                  | Month, Day, Yes  | While     | NJURY OCCURRED  Not while at work |          | ACE OF INJURY (Hame<br>tary, street, affice blds |                        | ly or lown)                            |                   | (County)         |                    | (Stote)               |
|     |               | saw the decease<br>220 SIGNATURE<br>22c PHYS CIAN S<br>NAME (Type)        |  | 1 2'      | ded the deceased 7, 19.60, and    | that d   | eath occurred at  ATTENDING PHYS  22d ADDRESS    | M, from                | the causes ar                          | nd on th          | e date           | stated             |                       |
|     | 23a           | BURIAL CREMAT ON REMOVAL (Specify)  | July 30-   |           | Brover H                          |          | R CREMATORY                                      |                        | ATION (City, town,<br>apolis, Ils      |                   |                  | (Stal              | e)                    |
|     | 24            | FUNERAL DIRECTOR'S C.E.Hicker 1   |  | polis     | ADDRESS                           |          |  | REC'D BY REGI          |  | STRAR'S S         |                  |                    |                       |



| 0 ( 6 )  | CERTIFICA  | TE OF DEATH   |  |  | 001  | 70   |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| CE OF DEATH  |  |   | ere deceased tive  |  | Residence befare   | admission)   |  |  |  |
|  | HORNORE  | Maryland  |  |  | tore-  |  |  |  |  |
| LITY OR TOWN (If autside carporate limits, w   |  | outside corporate   |  |  | ist fown)  |  |  |  |  |
|  | 6mo. 11 days   | Baltimore   |  | 1.   | 1 /  | 1  |  |  |  |
| NAME OF HOSPITAL (If not in haspital, give s   |  | d. STREET ADDRESS   |  |  | e  | IS RESIDENCE   |  |  |  |
|  | pital  | 1840 N. Ca  | roline a   | Street   |  | YES NO   |  |  |  |
| ME OF First  | Middle   | last  | 4. DATE  |  | Day  | Year   |  |  |  |
|  |  | Smith   | DEATH  | 7  | 30   | 1960   |  |  |  |
| 6. COLOR OR RACE 7.  | MARRIED NEVER MARRIED  | B DATE OF BIRTH   | 9. A   | - T.   |  | F UNDER 24 HI  |  |  |  |
| Female Negro with  | DOWED DIVORCED   | 1910  | lo   | 50 yrs.  | Months Days  | Hours Min  |  |  |  |
| SUAL OCCUPATION (Give kind of work done  | 106 KIND OF BUSINESS OR INDU   | STRY 11 BIRTHPLACE (State   | ar fareign cauntr  | y)   | 12 C TIZEN OF V  | VHATCOUNTR   |  |  |  |
|  |  | N mth Co  | antlone  |  | II S A   |  |  |  |  |
| THER'S NAME  |  |   |  |  | UşDaz  |  |  |  |  |
| akmown   |  | Tinknown  |  |  |  |  |  |  |  |
| AS DECEASED EVER IN U.S. ARMED FORCES?   | 16 SOCIAL SECURITY NO 17. I  |   |  | Addre  | 55   |  |  |  |  |
| known  | Unknown  | Hospital Red  | cords  |  |  |  |  |  |  |
| 18 CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c)-] INTERVA. BETWEEN IONSET AND DEATH   |  |   |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   | Congest  | ive Heart Fail  | lure   |  | ONSE   | I ANU DEATH  |  |  |  |
|  |  |   |  |  |  |  |  |  |  |
| Conditions, if ony, which ) Hypertensive Arteriosclerotic Cardiovascular Disease   |  |   |  |  |  |  |  |  |  |
| gave rise to immediate DUE TO  |  |   |  |  |  |  |  |  |  |
| lying couse last. (c)  |  |   |  |  |  |  |  |  |  |
|  | ONS CONTRIBUTING TO DEATH BU   | T NOT RELATED TO THE TERM   | INAL DISEASE CO  | nd tion give   | N IN PART 1(a) 19  | WAS ALTOPS   |  |  |  |
| Severe Mental Deficiency  PERFORMED? YES NO D  |  |   |  |  |  |  |  |  |  |
| Severe Mental Deficiency    Source   Severe Mental   Severe   Seve |  |   |  |  |  |  |  |  |  |
| 20g ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of Item 18 )  OR CONTRIBUTING   CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |  |  |
| EITHER, NOTIFY MEDICAL EXAMINER)   |  | ED (Enter nature at injury in   | Part I ar Part II a  | fitem 18)  | 344-14   | YES NO   |  |  |  |
| EITHER, NOTIFY MEDICAL EXAMINER)   |  | ACE OF INJURY (Home, form   | . <sup>1</sup> 20f (City ar t  |  | (County)   |  |  |  |  |
| c TIME OF INJURY Month, Day, Year 2  | Vhi.eNat whilefa   |   | . <sup>1</sup> 20f (City ar t  |  | (County)   |  |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour a m   | Yhi.eNat whilefa<br>t wark at wark   | ACE OF INJURY (Home, formatically, street, office bldg , etc.   | 20f (City ar t   | own)   |  | (Sta   |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour a m. 19 p. m. 19 1 certify that (1) (this hospital) at  | Yhi.eNat while for twork □ at wark □ tended the deceased fram.   | ACE OF INJURY (Home, form clary, street, office bldg, etc.  | 20f (City ar t   | own)   | _, 19.60 tha   | (Sto   |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour o m   | Yhi.eNat while for twork □ at wark □ tended the deceased fram.   | ACE OF INJURY (Home, formatically, street, office bldg , etc.   | 20f (City ar t   | own)   | _, 19.60 tha   | (Sic   |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour a m. 19 p. m. 19 1 certify that (1) (this hospital) at  | Yhi.eNat while for twork □ at wark □ tended the deceased fram.   | 1/19 19.  death occurred of 11.  ATTENDING M  | 20f (City ar t   | 30 causes ond  | _, 19.60 tha   | t (!) (we) lostated obov   |  |  |  |
| TIME OF INJURY Month, Day, Year 2 Mour a m. 19 a least the deceased alive on 17 and 20 SIGNATURE.  | Yhi.eNat while for twork □ at wark □ tended the deceased fram.   | 1/19 19 death occurred of 11 ATTENDING M.D PHYS   | 20f (City ar t   | causes ond   | _, 19.60 tha   | (Sto   |  |  |  |
| TIME OF INJURY Month, Day, Year 2 Mour a m. 19 a least the deceased alive on 17 and 20 SIGNATURE.  | tended the deceased fram.  100 ond that  | 1/19 19.  death occurred of 11.  ATTENDING M  | 20f (City art  | dayses and   | _, 19. <b>60</b> that on the date :  | (Stated obove 22b DATE SIGN B/1/60   |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour a m. 19  I certify that (I) (this hospital) at the deceased alive on 19  SIGNATURE OF INJURY Month, Day, Year 2  Very Month, Day,  | tended the deceased fram.  7,60, and that a summer.  1 summer, M. D.   | 1/19 19 death occurred ot 11: ATTENDING M.D PHYS: 22d. ADDRESS Crownsvill   | 20f (City ar to  | /30<br>causes ond  | _ 19.60 that on the dote :   | t (I) (we) lostated obove 22b DATE SIGN B/1/60   |  |  |  |
| TIME OF INJURY Month, Day, Year 2 Mour a m. 19 a least the deceased alive on 17 and 20 SIGNATURE.  | tended the deceased fram.  100 ond that  | 1/19 19 death occurred ot 11: ATTENDING M.D PHYS: 22d. ADDRESS Crownsvill   | 20f (City ar to  | dayses and   | _ 19.60 that on the dote :   | t (I) (we) lostated obove 22b DATE SIGN B/1/60   |  |  |  |
| CTIME OF INJURY Month, Day, Year 2 Hour o m. 19 a 19   | tended the deceased fram.  10. 1960, and that the same of the condition of | ACE OF INJURY (Home, form clary, street, office bldg , etc.)  1/19 19 death occurred of 11;  ATTENDING M.D. PHYS. D. D. 22d. ADDRESS Crownsvill  OR CREMATORY | 20f (City or 1   | Causes and Hospita   | _, 19.60 that on the dote :  | (State) (State) (State) (State) (State)  |  |  |  |
| c TIME OF INJURY Month, Day, Year 2 Hour a m. 19  I certify that (I) (this hospital) at the deceased alive on 19  SIGNATURE OF INJURY Month, Day, Year 2  Very Month, Day,  | tended the deceased fram.  7,60, and that a summer.  1 summer, M. D.   | ACE OF INJURY (Home, form clary, street, office bldg , etc.)  1/19 19 death occurred of 11;  ATTENDING M.D. PHYS. D. D. 22d. ADDRESS Crownsvill  OR CREMATORY | 20f (City ar to  | Causes and Hospita   | _ 19.60 that on the dote :   | (State) (State) (State) (State) (State)  |  |  |  |
|  | Crownsville Crowns | Anne Arundel  LITY OR TOWN (If autside carporate limits, write it RAL and give nearest town)  Crownsville   | Anne Arundel  CITY OR TOWN (If outside corporate limits, write clength of Stay in 1b cling in earest town)  Crownsville  NAME OF HOSPITAL (If not in hospital, give street address)  Crownsville State Hospital  Me Of First  Middle  Lost  EASE  Me Of First  Middle  Lost  Smith  6. COLOR OR RACE  Negro  WIDOWED  DIVORCED  DIVORCED  DIVORCED  1910  SUAL OCCLPATION (Give kind of work done life for varking life, even if retired)  Inknown  Substitution  Crownswille State Hospital  Analysis Middle  Lost  Smith  B DATE OF BIRTH  1910  SUAL OCCLPATION (Give kind of work done life for varking life, even if retired)  Inknown  SUBSTITUTION  SUAL OCCLPATION (Give kind of work done life for varking life, even if retired)  Inknown  SUBSTITUTION  THER'S NAME  ILA. MOTHER'S MAIDEN N  Unknown  CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).]  PART II. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, if ony, which gave rise to immediate ouse (a), stating the underlying couse lost.  PART II. OTHER SIGNIF CANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINATE CONTRIB | Anne Arundel  CITY OR TOWN (If autside carporate limits, write iteration of give nearest town)  Crownsville  NAME OF HOSPITAL (If not in hospital, give street address)  CR INSTITUTION  Crownsville State Hospital  Me OF RASE  First  Maryland  C CITY OR TOWN (If autside corporate limits, write iteration)  Baltimore  d. STREET ADDRESS  Baltimore  d. SALDRESS  BAO N. Caroline  STREET ADDRESS  BAO N. Caroline  STREET ADDRESS  BAO N. Caroline  STREET ADDRESS | Anne Arundel  Anne Arundel  Crown (if auside carporate limits, write common village and give nearest town)  Crownsville  Saltimore  Assert Address  Assert Address  Crownsville State Hospital  Assert Address  First Middle Lost Assert Address  Baltimore  Assert Address  Crownsville State Hospital  Assert Address  Female  Assert Address  Female  Assert Address  Assert Address  Female  Assert Address  Assert Address  Assert Address  Baltimore  Assert Address  Assert Address  Assert Address  Assert Address  Assert Address  Baltimore  Assert Address  Assert Address  Assert Address  Baltimore  Assert Address  Baltimore | Anne Arundel  Anne Arundel  City Or Town (if auside carporate limits, write composite limits composite limits cannot composite limits cannot limits composite limits cannot limits cannot limits cannot limits cannot limits c |  |  |  |

with ars after death. Page 4 TO HO My Land by the hospital ar attending physicion.

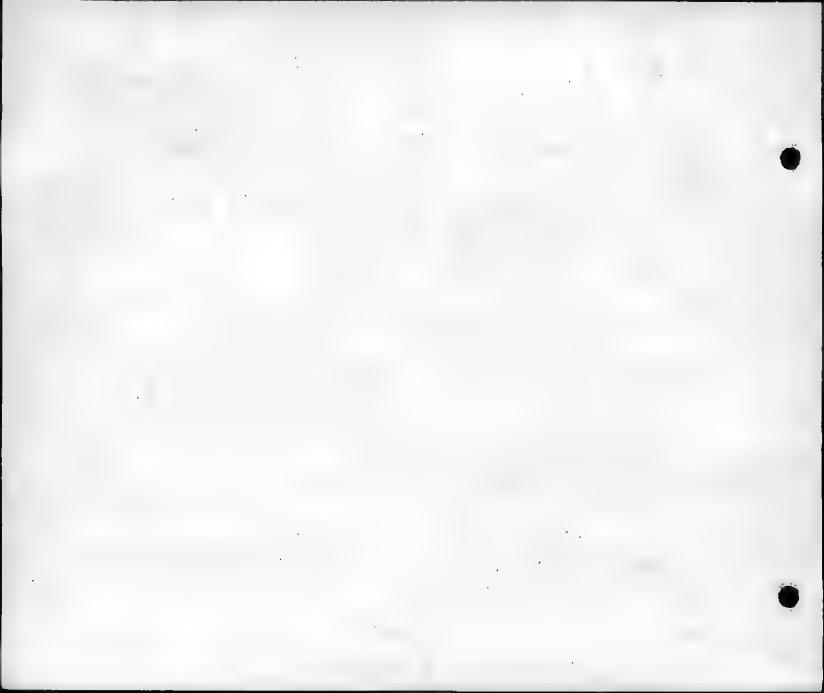
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please carbon papers. Pages 1 and 2 should be the State Board of Health prior to buriol, aremotion, or removal, and in any event, within 72 haurs ofter death.

VR A1S (4) 1SM 9/59



| 1   | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |
|---|--|--|
|   | 7657 Items 7,8,9,11,262 TIFICATE OF DEATH 7/14/60 iwk  | Dist. 0.7633                                       |
| Page 4  | 1 PLACE OF DEATH 2 USUFIL RESIDENCE (Where deceased lived if institution Residence of the COUNTY COUNTY)   |  |
| funeral funeral   | b CITY OR TOWN (If autside torporate limits, write c LENGTH OF STAY (I) 1b c. CITY OR TOWN (If outside torporate limits, write RURAL on RURAL and Give nearest tay)  | d give nearest towal                               |
| by the  | d. NAME OF HOSPITAL (If not in hospital) give street address of NSMITUTION 120 Take Hospital 420 Tyers Mills Rd.   | o is residence<br>on a farm?<br>yes \( \) no \( \) |
| filled in ges 1 an  | 3 NAME OF DECEASED (Type or print) Joshud Middle SMOTHERS OF DEATH 17  | Day Year 68  |
| letely f  | 5 SEX   6. COLOR, OR RACE   7 MARRIED   NEVER MARRIED   8. DATE OF BIRTH   1 8 9   9 AGE (In years lost birthdof)   Month  | ER 1 YEAR IF JINDER 24 HRS<br>S Doys Hours Min     |
| d comp  | 100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State of foreign country)  during most of working life, even if retired)  Maryland  | TITIZEN OF WHATCOUNTRY?                            |
| corbor<br>corbor<br>after   | 13. FATHER MAME SRS SMOTHERS MAIDEN NAME 12412   |  |
| certifico<br>na chysic<br>remove<br>72 hours  | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address (If yes, give wor or dotes of service)  |  |
| he deoth<br>of offending<br>of within   | 18. CAUSE OF DEATH [Enter only one cause per fine for (a), (b) and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a),  PART I. DEATH WAS CAUSED BY:   | INTERVAL BETWEEN<br>ONSET AND DEATH                |
| s that the day the nut. The   | Conditions, it only, which to Cerebral Thromposis  |  |
| on. signectification of the control | gave rise to immediate course (a), stating the under- lying course lost  (c) Jyhhilis of the Central Nervous Jystem  |  |
| physicion os been all transcription oval, a   | HAME I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEAS CONDITION GIVEN INTERPRETATION OF THE PRIMARY OF THE CONDITION GIVEN INTERPRETATION OF THE PRIMARY OF THE CONDITION GIVEN INTERPRETATION OF THE PRIMARY OF THE PRIMA | PERFORMED?   |
| AN: The pending ficate he burner or rem   | 200. ACCIDENT WAS UNDERLYING OF DESCRIBE HOW INJURY OCCURRED (Enter not) re of injury in Port I or Port II of item 18 )  OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| PHYSICI<br>al ar oth<br>this certif<br>r use os<br>emation,   | 20c. TIME OF INJURY Month Day, Year 20d INJURY OCCURRED Haur a. m.  Pm. 19 at work of ot wark foctory, street, office bldg., etc.)   | (Caunty) (State)                                   |
| NDING<br>e hospit<br>: After<br>ched fa<br>urial, cr  | 21. I certify that I divended the deceased from  | lost sow the deceosed                              |
| d by the deta be deta be deta   | ACTUAL Like Man M. C. COLLOW Con Control of the Man M. C. COLLOW CO. STORES (Street, claybe, store)  | OSPAD 94   |
| RAL DIRECT Should be stror prior  | PHYSICIAN'S LIGHT MEHTY MEDOM) Crochsville, Ald  | 177  |
| Moy be moy be puge 3 should the registrol   | 220 BUR AL CREMATION, 22b. DATE THEREOF / 22c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) BURIAL July 1960 Ash Memorial Sandy Upring. M  |  |
| VS A15 (4)  | 23 FONERAL DIRECTOR'S SIGNATURE ADDRESS CONTRACTOR DATE 240. REGISTRAP'S   | - 11   |
| 15M 9/58  | Harry C. Larran Harrison   |  |

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 rs after death. Page 4



VR A15 (4) 15M 9/59

7608

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

|  |  | 0 | 7 | 6 | 3 | 4 |
|--|--|---|---|---|---|---|
|--|--|---|---|---|---|---|

|   |  |   |                              |   | 4                               |   |
|---|--|---|------------------------------|---|---------------------------------|---|
|   | PLACE OF DEATH   | 7. (1:  | MARYLAND                     | 2 USUAL RISIDENCE (When   | e deceased lived   If institut  | ion. Restdence before admission)                        |
| ) | RLRAL and give no  | f outside corporate limits, write   | c. LENGTH OF STAY IN 16      | Pry or town (if of  | side corporate limits, virue l  | RURAL and have appress town)                            |
|   | d NAME OF HOSPIT   | AL IV not in hospital give Stre   | et oddresaty                 | d STREET ADDRESS  | 2000                            | IS RESIDENCE ON A FARM? YES IN NO ST                    |
|   | 1 1/1/00   |   | 7 - +                        |   | reco                            | TES NO Z  |
| i | 3. NÁME OF<br>DECEASED<br>(Type or print)                | John  | Middle                       | Sorrell   | OF DEATH                        | Day Year  |
|   | 5. SEX Male  | 1/11/00/  | WED MENTED DIVORCED          | 2 = 1 = 188 = 3   | 9. AGE (In years lost birthdoy) | Months Days Hours Min                                   |
|   | during most of wor                                       | ON (Give kind af wark dane ) king life, even if retired)                  | 16. KIND OF BUSINESS OR INDI | ISTRY IT BIRTHPLACE (State of                                   | foreign country)                | 12 CITIZEN OF WHAT COUNTRY?                             |
|   | 13. FATHER'S NAME  |   | 22200                        | 14. MOTHER'S MAIDEN NA  | IME I                           | 8 22 2 2 8 6  |
|   | 15 WAS DECEASED EVE                                      | R IN U. S. ARMED FORCES?  | 6. SOCIAL SECURITY NO 17     | INFORMANT,  | Musike Add                      | SO CLER   |
|   | 110  |   | ///                          | accontion   | roard 19                        | matellar.   |
|   | PART I. DEA  | ATH [Enter only one couse pe<br>ATH WAS CAUSED BY:<br>AMMEDIATE CAUSE (o) | line for (a), (b), and (c)   | mo / St   | owach                           | ONSET AND DEATH   |
|   | 1-1  | DUE TO  |                              |   |                                 | 3 mss   |
|   | Conditions, if a<br>gove rise to i<br>couse (a), stating | mmediate ( DUE TO   |                              |   |                                 | 3   |
|   | lying couse lost.  | (c)   |                              |   |                                 |   |
|   | PART II. OTH   |   | IS CONTRIBUTING TO DEATH BU  | T NOT RELATED TO THE TERMIN                                     | AL DISEASE CONDITION G          | VEN IN PART 1(0) 19 WAS AUTOPSY                         |
|   | icat   |   |                              |   |                                 | PERFORMED? YES NO                                       |
|   | OR CONTRIBUTING  | AS UNDERLYING () 206 (<br>G CAUSE OF DEATH<br>MEDICAL EXAMINER)           | ESCRIBE HOW INJURY OCCURR    | ED (Enter noture of injury in Po                                | ort for Part II at them IB)     |   |
|   | 20c. TIME OF INJUR<br>Have o. m<br>p. m.                 | w   |                              | LACE OF INJURY (Home, form, octory, street, office bldg., etc.) | 20f. (City ar town)             | (County) (State)  |
| , | 21 <b>I certify</b> that                                 | 1 -/  | nded the deceased fram       |   | to 7                            | , 19, that (I) (we) last<br>nd an the date stated abave |
|   | 220. SIGNATURE   | Trees   | / and that                   | ATTENDING MED   | ) STAFF                         | 22b. DATE<br>SIGNED                                     |
|   | 22c. PHYSICIAN'S   | 1. 00-  |                              | M.D PHYS. DIR   | ECTOR PHYS.                     | C-4   |
| į | NAME (Type)  | - TAL   | LEN                          | 6200  | -enercy                         | 24  |
|   | 230. BURIAL CREMATIC                                     | 0N, 236 DATE THEREOF  | 23c NAME OF CEMETERY         | OR CREMATORY  | In IMP IN                       | Contounty) Mistale                                      |
|   | PA) FUNERAL DIRECTOR                                     | 's SIGNATURE  | DODRESS                      | CANAL 250. REC'D DATE JUL                                       |                                 | ISTRAR'S SIGNATURE                                      |
|   |  |   |                              |   |                                 |   |



CERTIFICATE OF DEATH 76001. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY **b** COUNTY NE ARRV MARYLAND ofter death. b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. STREET ADDRESS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hospital NAME OF Middle Last 4. DATE DECEASED OF (SOUTAR) DEATH (Type or print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED 8. DATE OF BIRTH loss birthday) Months WIDOWED TO DIVORCED [ 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working/life, even if refired) 12. CITIZEN OF WHAT COUNTRY? Scotland Scotland puo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Helen Cunningham James A. Watson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address ottending 18. CAUSE OF DEATH [Enter only one couse per life for (o), (b), and (c).] PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Pyelo nephritio þ Conditions, if any, which gned gove rise to immediate DUE TO Per coese (a), sloting the underlying cause lost, **buriol-transit** PAID II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 20g ACCIDENT WAS UNDERWING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY 20e PLACE OF INJURY (Home, farm, 20f, (City or town) Month, Doy. 20d. INJURY OCCURRED Year factory, street, office bldg., etc.) Hour a, m. White Not while of work of work 21. I certify that I attended the deceased from buriol, (2) that I last saw the deceased be detoched alive an and that death accurred M, fram the causes and an the date stated above. DIRECTOR: ADDRESS (Street, city or to 2 ACTUAL should PHYSICIAN'S NAME (Type) FUNE 7-28-60 22c. NAME OF CEMETERY OR CREMATORY
Glen Haven Cemetery BURIAL CREMATION, 22d. LOCATION (City, town, or county) Glen Burnie, Maryland 0 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240. REC'D 8Y REGISTRAR 24b REGISTRAR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street JUL 26'60 Orthur S. Thous

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. IS RESIDENCE

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(County)

ON A FARM?

YES NO DE

Year

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INTERVAL BETWEEN ONSET AND DEATH

20 Mrs

WAS AUTOPSY PERFORMED?. YES | NO P

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FUNERAL DIRECTOR:

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attending physician.

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ATTENDING PHYSICIAN: The law requires that the death certificate be



8 DIRECT D ă 0 VS A15 (4)

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burial-transit

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5. SEX

after death.



director, s after death. Page the funer pluods TO HOST C. OR ATTENDING PHYSICIAN: The faw requires that the death certificate be executed within 24 may be and by the haspital ar attending phys clan.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending phys.cian and camplete y filled in by page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 in the State Board of Health priar to burial, cremation, ar remaval, and in any preset within 72 haurs after death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

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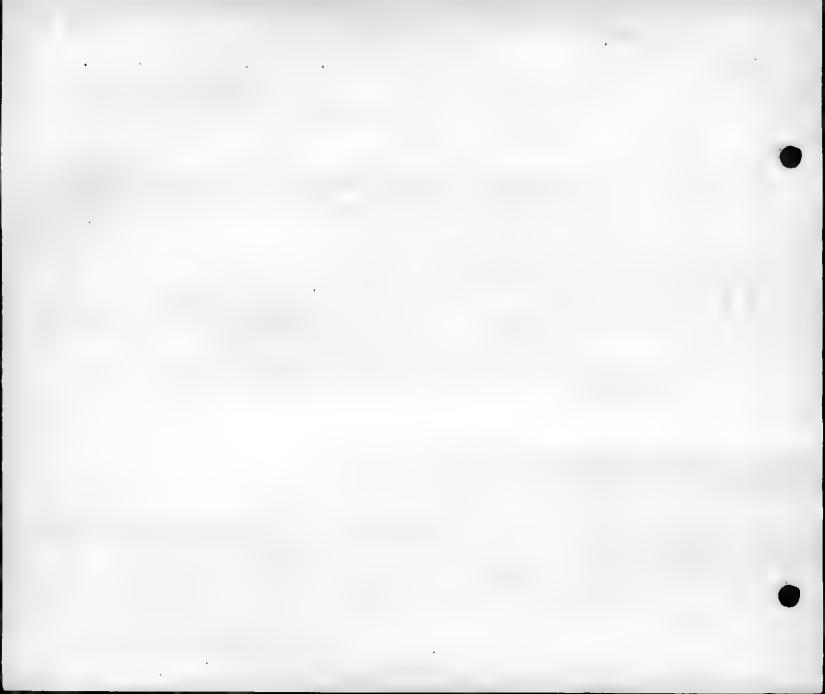
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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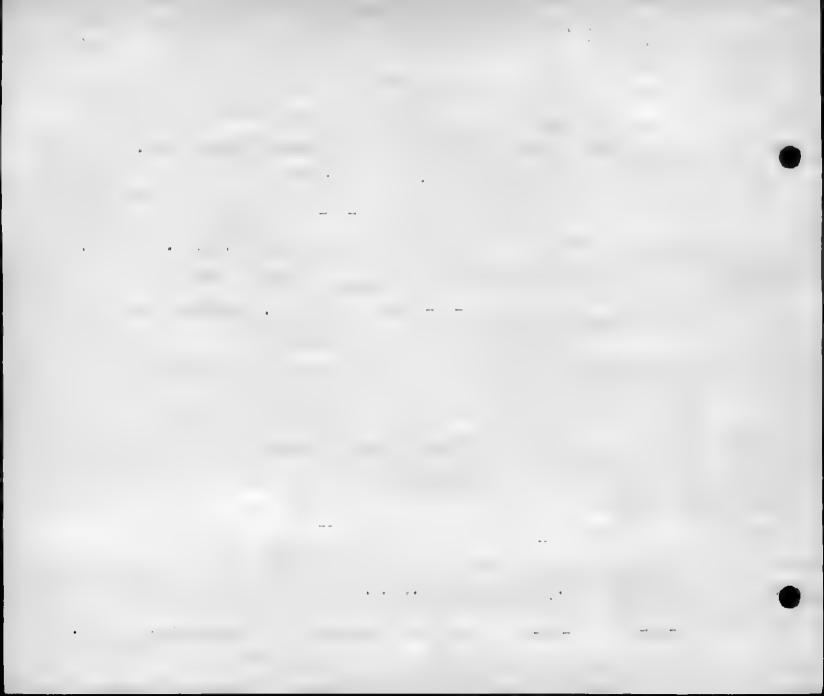
|   |                | 1000   |   | CERTIFICA          | E OF DEATH  |                           |                         |  |
|---|----------------|--|---|--------------------|---|---------------------------|-------------------------|--|
|   |                | LACE OF DEATH  | a.  | MARYLAND           | 2. USUAL RESIDENCE (W                                     |                           | rinstitution, Residence | before admission)                            |
|   | <b>≪</b> d₹    | RURAL and give nearest town  | porate limits, write c. LENC                  | OTH OF STAY IN 16  | . ac. City or town (If)                                   | butside corporate limits, | write RURAL and give    | re neorest town)                             |
| 4 | d              | OR INSTITUTION   | haspital, give street address)                |                    | d. STREET ADDRESS   |                           |                         | e. IS RESIDENCE<br>ON A FARM?<br>YES NO      |
|   | D              | IAME OF DECEASED (Type or print)   | First   | Middle             | taylar  | 4. DATE<br>OF<br>DEATH    | Month                   | Doy Year<br>13 196                           |
| _ | 5 S            | zemale Co  | OR BATTE 7 MARRIED N                          | DIVORCED           | 2-12-189  | 9 AGE fi                  |                         | YEAR IF UNDER 24 HRS<br>Doys Hours Min.      |
|   | 10a            | USUAL OCCUPATION (G ve kindering most of working life even                                       | d of work dane 10b. KIND OI                   | BUSINESS OR INDUS  | TRY TI BIRTHPLACE (State                                  | or foreign country)       | 2 12 47                 | EN OF WHAT COUNTRY                           |
|   | 13 F           | TATHER'S NAME Samu   | rel Ba  | itler              | 14 MOTHER'S MAIDEN  | PALEC.                    | But                     | ter,   |
| ) | 15. \<br>(Yes. | MAS DECEASED EVER IN U. S. A   | RMED FORCES? 16. SOCIAL ror doles of service) | SECURITY NO 17 IN  | da Shor   | nas m                     | Address<br>AULO         | md   |
|   |                | PART I. DEATH WAS CA   | USED BY: (d)                                  | ure ()             | seve -  | - uren                    | vio                     | INTERVAL BETWEEN ONSET AND DEATH             |
|   |                | Canditions, if any, which gove rise to immediate couse (a), stating the under- lying couse last. | (b) DUE TO                                    | rgist              |   | ·acou                     |                         |  |
|   | FICATION       | PART IT OTHER'S GNIFIC   | CANT CONDITIONS CONTRIB                       | UTING TO DEATH BUT | NOT RELATED TO THE TERM                                   | linal d sease condit      | ION GIVEN IN PART       | 1(0) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
|   | CERT           | 200. ACCIDENT WAS UNDERLY!<br>OR CONTRIBUTING [] CAUSE (<br>(IF EITHER, NOTIFY MEDICAL EX        | OF DEATH                                      | OW INJURY OCCURRED | (Enter nature of injury in                                | Part I or Part II of item | , 1B.)                  |  |
|   | MEDICAL        | 20c TME OF INJURY Month,<br>Hour o.m.<br>p. m.   | While No                                      |                    | CE OF INJURY (Home, fari<br>ary, street, office bldg., et |                           | (Ca                     | unty) (State                                 |
|   |                | 21 I certify that (I) (this saw the deceased alive   | 1111-6  | )                  |   | M, from the cau           |                         | _, that (I) (we) lost<br>dote stated above   |
| 7 |                | 220 SIGNATURE  | Cally   | A                  | D. PHYS A D   | AED STAFF                 |                         | 226 DATE<br>SIGNED                           |
|   |                | 22c PHYS CIAN'S<br>NAME (Type)   | TALL  | 6 N                | 22d ADDRESS   | echd                      | and St                  |  |
|   | 10             | BURIAL, CREMATION, 23b. DA<br>PREMOVAL (Spec fy)   | 17-60 H                                       | AME OF CEMETERY OF | MEDRE.  | 23d LOCATION (City        | ate.                    | ) ] [51gfe]                                  |
|   | 24) 1          | FUNERAL DIRECTOR'S SIGNATOR  | esett.  | DORESS MANAGE      | DATE JI   | 0 0 100                   | Sto REGISTRAR'S SIGN    | 1 -  |

VR A15 (4) 15M 9/59



| 1  | Division of STATISTICAL RESEARCH AND RECORDS, JUL W. PRESTON STREET, BALLIMORE 1, MAR  | RYLAND                        |
|--|--|-------------------------------|
| FOR STATE  | (UL) MEDICAL EXAMINER'S CERTIFICATE OF DEATH   | 7639                          |
| HEALTH DEPT.   | 1. PLACE OF DEATH   2. USUAL RESIDENCE (Where deceased fived, if institution; Reside   | ince before edmission         |
| 1 E 2 2  | a. COUNTY Anne Arundel  Maryland  Anne Arundel  Anne Arundel  Anne Arundel  Anne Arundel   | V                             |
| SE IVI /   | b. CITY OR TOWN (f outside corporate I mits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give  | gomery                        |
| 25 5 5 5   | write RURAL and giy(s)hearest lown) , //   | 15 2                          |
| Tall you   | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address TREET ADDRESS  | a. IS RESIDENLE               |
| yello<br>Jen<br>Boss   | Anna Anna 1 2 G anna 2 H anta 2  | ON A FARM?                    |
| ate ate  | Anne Arundel General Hospital " 113 Melbourne Ave.   | YES NO                        |
| atari<br>estari<br>dea   | 3. NAME OF Frst Middle Last 4. DATE Month Dey DECEASED OF  |                               |
| F # 5 F F  | (Type or print) LESLIE M. THOMPSON DEATH July 2  |                               |
| 4年2月1日   | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yeers IF UNDER 1 YEAR   |                               |
| ma ma 2 v 2 v Surs   | Male   White   widowed   Divorced   1-25-99   60 yrs.  | Hours Min.                    |
| 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  |  | OF WHAT COUNTRY?              |
| Pss 1. ag  |  | S. A.                         |
| 1 8 8 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4  | 18. FATHER'S NAME  | D • 'W'• _                    |
| 20 M M M M M M M M M M M M M M M M M M M   | William M. Thompson Nannie Downs   |                               |
| F E E  | 15 WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. 17. INFORMANT Address   | -m                            |
| 1.2 E. 2 E   | {Yes, no, or unkown}   (Ifyesgivewerordetesofservice)  | "0                            |
| with a sun a   | Dolo on a contract Dame of   | NIERVAL BETWEEN               |
| in I<br>ng<br>ng<br>isit   | DARTE BEATH WAS CAUSED BY  | NSET AND DEATH                |
| and and  | Hemopericardium with cardiac tamponade   | ~1                            |
| d b per line line line line line line line line  | DUE TO   |                               |
|  | Cond hors, if eny, which to Rupture of dissecting aneurysm of ascending aorta  |                               |
| 120 PT S TE S  | (e), stetling the underlying DUE TO  |                               |
| end<br>end<br>ad a   | cause last, (c)  | Partia                        |
| Tion in the second seco   | PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1:01  | 19. WAS AUTOPSY<br>PERFORMED? |
| is conditional land  | PART 1. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1161  206. EXTERNAL CAUSE WAS 206. DESCRIBE HOW INJURY OCCURED. (Enter nature of in ury in Part I or Part II of Illam 18.) PRIMARY   or CONTRIBUTING   CAUSE OF DEATH.  | YES NO                        |
| 는 Sign   | 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of in ury in Part I or Part II of illam 18.)   |                               |
| ER ST.   | CAUSE OF DEATH.  |                               |
| hiel<br>biel<br>bu   | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Homa, farm, 20f. (City or lown)  | (Steta)                       |
| AIM WIT WIT NO POS OF 1  | 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED 20a. PLACE OF INJURY (Homa, farm, 20f. (City or lown) (County) Hour a.m. While Not While at work at work at work at work Partial   |                               |
| EX<br>Se de Se | TATULA .   | d in my opinion               |
| AL DI  | death resulted from. Natural causes X. Accident . Suicide . Homicide . Undetermined manner   | ,,                            |
| SEC  | CHIEF MEDICAL EXAMINER   |                               |
| DIS A P  | 1  | DATE SIGNED                   |
| Y MED scute the be forware RAL DIR   | SIGNATURE DEPUTY MEDICAL EXAMINER D  | DATE SIGNED                   |
|  | EXAMINER'S W. Bradley King. Ir. M.D.   | 7/27/60                       |
| Se excloud ONE   | NAME (Type)  Address (Street, city, town, or county)  22e. BURIAL, CREMATON, 22b. DATE THEREOF, 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country)  | (Stata)                       |
| D S L F L  | REMOVAL (Spacify)  | 25.3                          |
| 0 g 4 0 p  | Burial 7-30-60 Rest Haven Camebery Hagerstown,  ADDRESS CALL 1246. REC'D BY REGISTRAR   246. REGISTRAR   246 | Md •                          |
| VS. A15ME  | 11 1 1 1 200 1 1 200 1 1 1 200 2 1 1 1 200 2 1 1 1 1   | 1-                            |
| 5M 7/59  | 17. J. Collins 3821-14-1WID. C. DATE MUBZ OF COLORS  |                               |
|  |  |                               |

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 7612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH TO DEFINATION MEMICAL EXAMILER: This certificate shauld be executed within 24 hours after Tests. If any rector, please execute the certificate, mining the word "pending" in general in Item 18. Give Pages 1, 2, and 3 to the function forces of a should be forwarded to the Chief Medical Examiner's Office along with form EM3. Page II may bit relatined for your files.

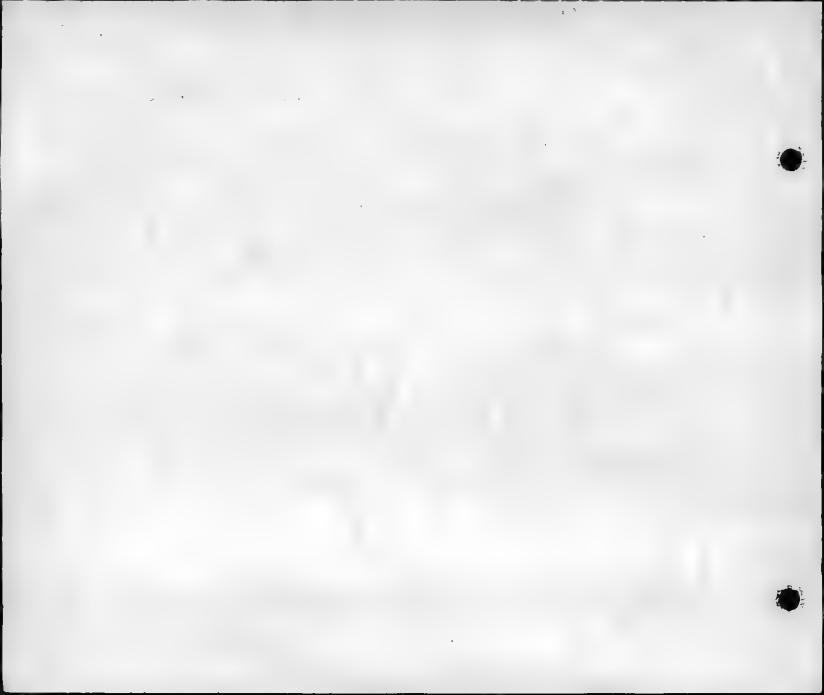
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, aremation,

Reg. (12.6.41)

|     | 1. PLACE OF DEATH A. A. C. C. MARYLAND   | 2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission)  o. STATE  b. COUNTY  |
|-----|--|--|
|     | b. CITY OR TOWN IN cytude corporate lands with the RURAL c. LENGTH OF STAY IN 16 and give recorest lourists and the property of the RURAL conditions o | c. CITY OR COMMY II DO COLOR PROTECTION AND SHEAL and give negrest towny   |
| ,   | d NAME OF HOSPITALTOR INSTITUTION (If not in hospital, give street oddress)  1. C. H. Hilliam Hican Cel Ginn   | d STREET ADDRESS  ON A FARM?  YES NOW  |
|     | 3. NAME OF DECEASED (Type or print) Price of 12.   | Tost 4. DATE OF DEATH POP 19 C   |
|     | M WIDOWED DIVORCED   | PATE OF BIRTH  9. AGE (in years lest by brinday)  9. AGE (in years   FUNDER 1YEAR IF UNDER 24 HRS.   Months   Days   Hours   Min.   Min |
|     | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired)  ATGA PENCO  | ma 034   |
|     | THOMAS H TODD, S.R.  | ELIZABETH SHERIDAN   |
|     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IMP   | ORMANT Address   |
|     | 18. CAUSE OF DEATH [Enter only one cause per line for (o). (b), and (c).]  PART I. DEATH WAS CAUSED 8Y: IMMEDIATE CAUSE (o)  | interfal Between onet and peal of the first  |
|     | Conditions, if any, which gove rise to immediate course (b) DUE TO   |  |
| ı   | couse lost. (c)  | OT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19 WAS AUTOPSY   |
|     | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO  20d. EXTERNAL CAUSE WAS 20d. DESCRIBE HOW-INJURY OCCURRED. (En)  | PERFORMED? YES NOTE: Or nature of injury in Part 1 or Part 11 of item 18.7*  |
| - 1 | CAUSE OF DEATH.  | atil army thelive itred  |
| ,   | Hour on 7 -16 196 of While of work of while  | OF INJURY (Home, form, 20f (City or town) (County) (State) y, street, office bldg., etc.)  |
|     | 21. I certify that I took charge of the remains described above death resulted from: Notural causes. Accident . Suici  |  |
|     | ACTUAL SIGNATURE Au Full   | M.D. CHIEF MEDICAL EXAMINER  |
|     | EXAMINER'S ELIN MARCHY   | ASSISTANT MEDICAL EXAMINER D DEPUTY MEDICAL EXAMINER D 7-16 6 C  |
|     | 220. BURIAR CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR C REMOVAL (Specify) 7/19/60 Milkeline  | Wash tarkville md  |
|     | 23. FÜNERAL DIRECTOR'S SIGNATURE S/ GADDRESS AL BULL S. BERRING  | DATE ALL 25'60 CALLOS & FLORE  |

VS. A15ME(5) 5M 9/55

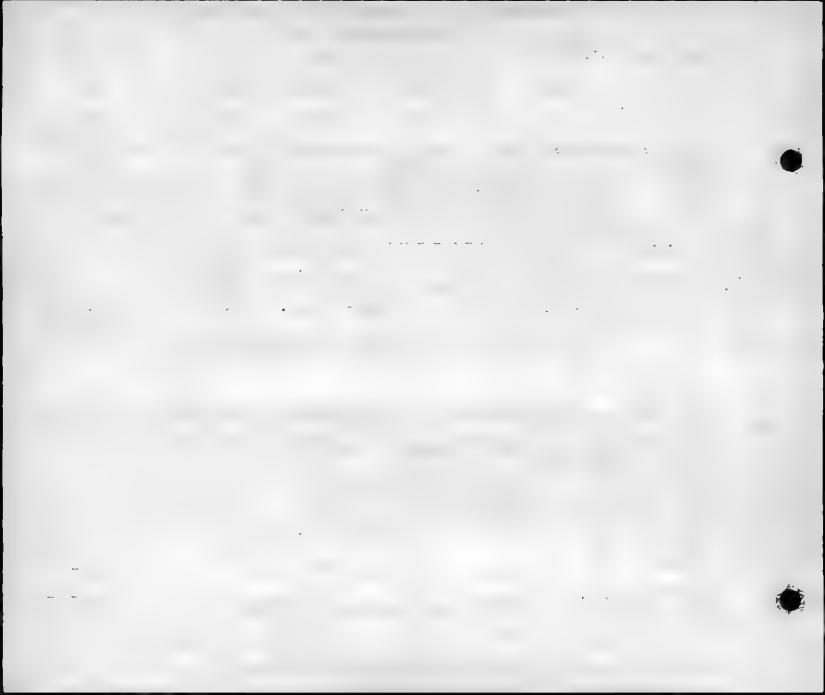
or removol.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 7613 Reg. Dist. No with l director, filed with 1 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. Il institution) Residence before admission) o. COUNTY b. COUNTY MARYLAND Anne Arundel Marry and Anne Arundel uneral b. CITY OR TOWN (If outside corporale limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 þe RURAL and give nearest lawn) P Annapolis Annenolis d NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NO TO 9 German Street Apparolis, Maryland NAME OF Middle Lost 4. DATE Month Year Day DECEASED (Type or print) Emanual Joseph TOPLE DEATH July 1960 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX B. DATE OF BIRTH P. AGE (In years last birthday) Months Days Male White WIDOWED | DIVORCED [7] papers. 78 yrs. 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY? er deat Wisconsin puo US! 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 103 physicion Frank 102 Katherine SMTRCINA поле 17. INFORMANT IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO Address Wife-Faith TOPLE. 9 German Street, Annapolis Hone 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ם PART I. DEATH WAS CAUSED BY: Adenocarcinoma Prostate with Metastases Unlanovm DUE TO permit. Conditions, if any, which gave rise to immediate **DUE TO** coese (o), stoting the underburial-transit premayal, and lying cause lost PART BL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES 🚻 NO 🗍 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature all injury in Part I or Port II of item 18.) CERT (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) Hour c. m. factory, street, office bldg., etc.) Not while at work al work p. m. 150 to July 15th 1960 that I last saw the deceased 21. I certify that I attended the deceased fram May 25th bornol, \_\_\_, and that death occurred at 7:50AM, from the causes and an the date stated above. de o ADDRESS (Street, city or town, stole) DATE SIGNED ACTUAL SIGNATURE USNH, Annapolis, Maryland prior 7-15-60 D PROTESTANCE C. LANING NAME (Type) 220. BURIAL CREMATION, 22b. DATE THEREOR 22c, NAME OF CEMETERY OR CREMATORY 22d. LOCATION [City, lown, or county] pode JREMOVAL (Specify) 2 230 FUNERAL DIRECTOR'S SIGNATURE -ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JUL 1 8 '60 VS A1S (4) ISM 9/SII

death.



| <u>a</u>   |   | 븡  |   |
|--|---|--|---|
| A OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24. It after death. P |   | AI DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral d <u>ir</u> | havid be detached for use as the burial-transit permit. Then please remaye capan papers. Pages 1 and 2 should be Miss |
| r de   |   | fune   | Pic.  |
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| 17   |   | by   | ğ   |
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VS A15 (4) 15M 10/57

| MARYLAND | STATE DEPARTMENT | OF HEALTH—BALTIMORE, | 18   |
|----------|------------------|----------------------|------|
|          | CERTIFICATE      | OF DEATH             | Day. |

07642 Rea, Dist. No.

| 7660  | CERTIFIC   | ATE OF DE   | ATH                             |  | Reg. Dist. No    |   |  |  |  |  |
|---|--|---|---------------------------------|--|------------------|---|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Anne Arundel  | MARYLAND   | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Maryland Anne Arundel |                                 |  |                  |   |  |  |  |  |
| b CITY OR TOWN (If outside corporate limits, write c. RURAL and give nearest lown)  Davidsonville                         | LENGTH OF STAY IN 1b   |   |                                 | profe limits, write R                  | URAL and give ne | arest lown)                               |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street odd OR INSTITUTION  Central Ave.                                     | ress)  | d. STREET ADDR  |                                 | 116                                    |                  | e. IS RESIDENCE<br>ON A FARM?<br>YES X NO |  |  |  |  |
| 3 NAME OF DECEASED (Type or print) ERNEST DE  | Middle<br>RUNDEL TUCK  | lost  | 4. DATE<br>OF<br>DEATH          | Mon<br>July                            |                  | 19 60                                     |  |  |  |  |
| 5. SEX 6. COLOR OR RACE 7 MARRIED WIDOWED   | NEVER MARRIED DIVORCED   | B. DATE OF BIRTH  | '&                              | 9 AGE (In years lost birthday) 8 Jyrs. |                  | Haurs Min                                 |  |  |  |  |
|   | Maintance  | STRY 11. BIRTHPLACE   |                                 | country)                               | USA              | OF WHAT COUNTRY?                          |  |  |  |  |
| John Thomas Tucker  |  | 14 MOTHER'S MA  | Rid ew                          | ау                                     |                  |   |  |  |  |  |
| 15 WAS DECEASEDEVER IN U. S. ARMED FORCES? 16, SOC [Yes, no. or unknown] [If yes, give war or dates of service] 20        |  | INFORMANT<br>Ss Seatric   | e E. Tuc                        | ker- Daus                              |                  | nt.3 as # 2                               |  |  |  |  |
| ICATIO  | gove rise to immediate couse (a), stoling the under lying couse lost.    Out to couse lost   Out to couse   Out |   |                                 |  |                  |   |  |  |  |  |
|   | E HOW INJURY OCCURRE   | ED (Enter nature of inj   | iry in Parl I or Pa             | rt II of item 18.)                     |                  |   |  |  |  |  |
| 20c TIME OF INJURY Month, Doy, Year 20d. INJU White of work   | Not while fq   | ACE OF INJURY (Homeoclory, street, affice bld   | e, form, 20f. (Cit<br>g , elc.) | y or tawn)                             | (Caunty)         | (State)                                   |  |  |  |  |
| 21. I certify that I attended the deceased alive on 7-1/2 10 60  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) James R. Martin | 2,-, and that death  |   | ADDRESS (S                      | n the causes a treet, city or town,    | nd an the da     | te stated abave. DATE SIGNED              |  |  |  |  |
| Butter July 14,60 A   | RE NAME OF CEMETERY O  |   |                                 | TION (City, town, o                    |                  | (Stole)                                   |  |  |  |  |
| For ing Funeral Home A  | ADDRESS  |   | REC'D BY REGISTE JUL 1 B        | TRAR 246 REGIS                         | TRAR'S SIGNATUS  |   |  |  |  |  |

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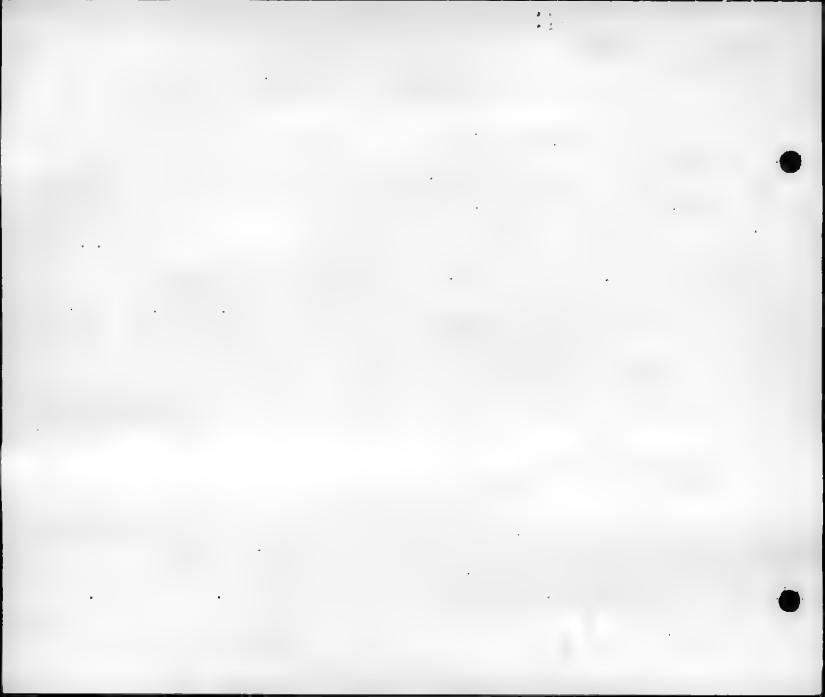
## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7614

07643

| 1 PLACE OF DEATH   | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)                   |
|--|--|
| Anne Arundel MARYLANI  | Maryland b. COUNTY Anne Arundel  |
| b CITY OR TOWN (If outside corporate timits, write   c LENGTH OF STAY IN 1 | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)                       |
| RURAL and give neorest town) Annapolis                                     | Annapolis  |
| d NAME OF HOSP TAL (If pat in hospitat, give street address)               | d. STREET ADDRESS e. IS RESIDENCE  |
| Anne Arundel Genera 1 Hospital   | 235 King George St., ON A FARM?  |
| 3. NAME OF First Middle  | Losi 4. DATE Month Day Year  |
| (Type or print) Rosalie PARTE  | P VAN NESS DEATH July 16 1960  |
| 5. SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED                            | B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR  |
| Female White WIDOWED DIVORCED  | 134 1881 lost biphiday) Months Days Hours Min.   |
| 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR IN   | 1001   |
| dufing most of working life, even if retired)  Home                        | Maryland U.S.  |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |
| Martin Martin  | Batter Maron   |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17     | INFORMANT Address  |
| (Yes, no, or unknown) [If yes, give war or dates of service]               | Casa on Tou Day Onexuson Mill M.   |
| 18. CAUSE OF DEATH   Enter only one couse per line for (of (b), and (c).)  | Interval Between   |
| PART I. DEATH WAS CAUSED BY:   | ONSET AND DEATH  |
| IMMEDIATE CAUSE (0)  | lugocero o 1 104. 39RS.  |
| T and a DUE TO   |  |
| Conditions, if ony, which (b)  | -//  |
| couse (o), stoting the under-  |  |
| lying couse lost. (c)  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH I               | RUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS' PERFORMED?        |
|  | YES NO X   |
| ☐   OR CONTRIBUTING □ CAUSE OF DEATH                                       | (RED (Enter nature of injury in Port I or Port (I of item 18 )   |
|  |  |
| Hour o. m. While Not while   | PLACE OF INJURY (Hame, farm, 20f (City or town) (County) (State factory, street, affice bldg., etc.) ( |
| p. m. 19 of work of work   |  |
| 21 I certify that (I) (this hospital) attended the deceased from           | n  |
| saw the deceased alive an 2-16 0 and tha                                   | t death occurred at AM, fram the couses and on the date stated above                                   |
| 220. SIGNATURE   | 6:40P.M. ZZb. DATE   |
| fre frest  | MD PHYS DIRECTOR PHYS 7/18/60  |
| 22c PHYSICIAN'S<br>NAME (Tool  | 22d. ADDRESS   |
| Elmer G. Linhardt  | 3 Chesapeake Ave., Annapolis, Md.  |
| 230 BURIAL, CREMATION 200 DATE THEREOF 230 NAME OF CEMETER                 | OR CREMATORY 23d LOCATION (City, town, or county) (Slote)  |
| Busice July 19=1960 Treaming   | ours Idons, 18a Lerseone Me  |
| 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS                                    | 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE   |
| John M. Jinja was amage  | DATE DATE  |
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| cuted within 24 hours offer death. If any is necknow, please | im 18. Give Pages 1, 2, and 3 to the funer actor. Yoge 4 shauld | arm PM3. Page 5 may be retained for your files. | A CANADA TO THE PARTY OF THE PA |
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07644

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.

| 3,            | MACE OF DEATH O. COUNTY Arine Ar   | undel  | A m.       | MARYLAN                                   |        | 2. USUAL RESI     |                          | here decec             | ed lived. If I<br>b. CO        |               | Residence<br>HOWS | -  | nission)          |
|---------------|--|--|------------|---|--------|-------------------|--------------------------|------------------------|--------------------------------|---------------|-------------------|--|-------------------|
|               | o. CITY OR TOWN (If and give negret leven)                                       | outside corporate limits, write  | RURAL      | c, LENGTH OF STAY IN 1                    | b      | c. CITY OR        | OWN (If                  | outside cor            | porole limits,                 | write RUR     | AL and giv        | re nearest t                               | own)              |
|               |  | G. Meade   |            | Few secon                                 | ds     |                   | Jess                     | up                     |                                | -             | M.                |  |                   |
|               | I. NAME OF HOSPITA   | L OR INSTITUTION (I  | not in     | hospital, give street address)            |        | d. STREET A       |                          |                        |                                |               |                   | e, IS                                      | RESIDENCE         |
|               | U. S. Ar   | my Hospita.  | L .        |   |        | A:                | rk Tr                    | ailer                  | Ct                             |               |                   |  | NO 3              |
|               | NAME OF<br>DECEASED<br>(Type or print)   | First ANI  |            | Middle                                    |        | VITALI            |                          | 4. DATE<br>OF<br>DEATH |                                | Month<br>July | T.                | 7  | Year<br>19 60     |
| 5 5           | Female   | 6. COLOR OR RACE   |            | RRIED NEVER MARRIED DIVORCED DIVORCED     | 8. D   | 11/21/            | 26                       |                        | 9. AGE (In year lost birthday) |               | INDER TYPE        |  | Min.              |
| 100           | . USUAL OCCUPATIO<br>luring most of working<br>Housew                            | N (Give kind of work of life, even if retired)                             | lone 10    | b, KIND OF BUSINESS OR INDU               | JSTRY  |                   |                          | or foreign o           |                                | 1             | 12. CITIZEN       | USA  | COUNTRY?          |
| 13.           | FATHER'S NAME  |  |            |   | 1      | 14. MOTHER'S A    | AAIDEN N                 | IAME                   |                                |               |                   |  |                   |
| )5.<br>(Yes   |  | R IN U. S. ARMED FOI<br>(II yes, give wer or dates of s                    |            | 16. SOCIAL SECURITY NO. 17<br>118-28-9609 | ,      | ormant<br>usband) | SP5                      | Richa                  | rd J V                         | itali         | i.                |  |                   |
|               | PART I. DEAT   | H [Enter only one cou<br>H WAS CAUSED BY:<br>IMMEDIATE CAUSE (o)<br>DUE TO | se per li  | Hodgin's dise                             | as     | e                 |                          |                        |                                |               |                   | INTERVAL BETWEEN ONSET AND DEATH  12 years |                   |
| NOI           | Conditions, if an gove rise to immed (0), stoting the ucause fost.  PART It. OTH | y, which aide couse DUE TO   | OITIONS    | CONTRIBUTING TO DEATH BU                  | T NO   | T RELATED TO      | HE TERM                  | NALDISEAS              | E CONDITION                    | GIVEN 1       | N PART 1(         |  | AUTOPSY<br>ORMED? |
| CERTIFICATION | 20g. EXTERNAL CAU<br>PRIMARY OF CON<br>CAUSE OF DEATH.                           | SE WAS   | b. DESC    | RIBE HOW INJURY OCCURRED                  | . (Ent | er nature of inj  | ry in Port               | l or Port II           | of item 18 )                   |               |                   | YES 🗌                                      | но 🎦              |
| MEDICAL C     | 20c. TIME OF INJUR<br>Hour g. m.<br>p. m.  | Y Month, Day, Yea  | W          | d. INJURY OCCURRED 20e. P                 | LACE   | OF INJURY (H      | ome, form<br>oldg., etc. | 20f (City              | or town)                       |               | (County           | )  | (Stole)           |
|               |  |  |            | e remains described al                    |        |                   |                          |                        | nspection<br>ndetermine        |               |                   | C, and                                     | find that         |
|               | ACTUAL SIGNATURE   | ustani,  | IK.        | Paulening                                 |        | M.D. CHIEF MI     | EDICAL EX                | AMINER [               |                                |               |                   | DATE                                       | SIGNED            |
|               | EXAMINER'S<br>NAME (Type)  | ustave H.  |            |   |        | ASSISTAN          | IT MEDIC                 | AL EXAMINE<br>EXAMINER | R 📙                            |               |                   | l Ju                                       | ly 60             |
| 220           | BURIAL, CREMATION<br>REMOVAL (Specify)   | N, 226. DATE THEREO  | F          | 22c. NAME OF CEMETERY                     | OR C   | REMATORY          |                          |                        | TION (City, to                 |               | ounty)            | (Sto                                       | te)               |
| 23.           | FUNERAL DIRECTOR   | S SIGNATURE  | 2774       | National ADDRESS                          |        |                   | 24a, REC'I               | D BY REGIST            | gton, Va<br>RAR 246. 1         |               | R'S SIGNA         | TURE                                       |                   |
|               | F.C.Hi   | grupoénom'   | ) -L -L -L | cott City, Md                             |        |                   | DATE 1                   | INT e                  | 90                             |               |                   |  |                   |

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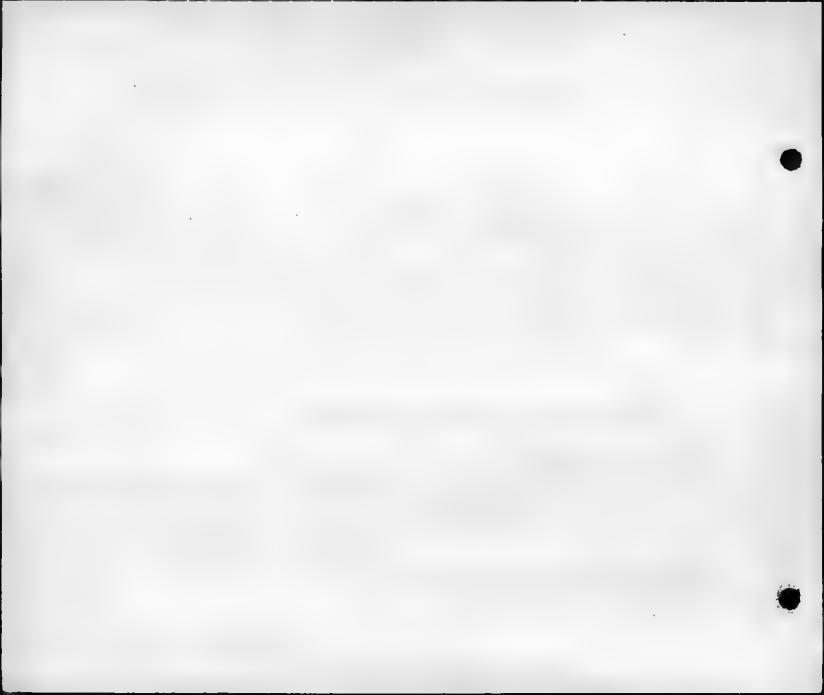
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| MARYLAND | STATE DEPARTMENT | OF HEALTH-BALTIMORE, | 18 |
|----------|------------------|----------------------|----|
| 7662     | CEDTIEICATE      | OE DEATH             |    |

FUU G CERTIFICATE OF DEATH

Reg. Dist. 0.7645

| 1. PLACE OF DEATH O. COUNTY A MARYLAND   | USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)     STATE     B. COUNTY |
|--|--|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   | c. CITY OR TOWN (If butside corporate limits, write RURAL and give nearest town)                           |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES NO   |
| 3 NAME OF First Middle DECEASED (Type or print)  | Lost 4. DATE Month Day Year OF THE TOP                                 |
| och emace  | B. DATE OF BIRTH  9. AGE (In yours   IF UNDER 1 YEAR) IF UNDER 24 HRS                                      |
| marked   Never Marked  | Sept 4   |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if retired) | TRY 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY                                   |
| 13. FATHER'S NAME  | 14 MOTHER'S MAIDEN NAME  |
| Thenry Cl Dallage  | hidia Prott  |
|  | NFORMANT Address   |
| [Vex. no or unknown] [If yes, give wor or defect of service] 217-3038954   | John Wallace, Dunbirk, md.   |
| 18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]   | INTERVAL BETWEEN   |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (O)  CATTURE  | treclusion ONSET AND DEATH   |
| DUE TO   |  |
| Conditions, if any, which) (b) autrosd   | eines  |
| gove rise to immediate couse (a), stating the under-   |  |
| lying cause lost. (c)  |  |
| Pairt II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I   | NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED?                 |
| 200 ACCIDENT WAS UNDERLYING 206 DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH                                | PES NO   |
|  |  |
| While Not while fac  | CE OF INJURY (Home, form, 20f (City or lawn) (County) (State) lary, street, office bldg., etc.)            |
| 21. I certify that I attended the deceased from  | 1950 to Mily (2 1960 that I last saw the decease   |
| alive an 14-1 1960 and that death  | occurred at 7 AM, from the causes and an the date stated above   |
| alive an, 1960 ,, and that death   | ADDRESS (Street, city or town, state)  DATE SIGNET   |
| SIGNATURE Tomily He heligh   | 1.0 Istuen ml. 7-14.6  |
| PHYSICIAN'S<br>NAME (Type)   |  |
| 22d BURIAL CREMATION, 226 DATE THEREOF 22c NAME OF CEMETERY OR   | CREMATORY 22d LOCATION (City, fown, or county) (Stote)   |
| REMOVAL (Specify) 7-16-60 MARCOL   | Bristal A.A. and   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE   |
| L.E. Sewell, Trince Frede  | ALCK DATESUL 19'80 (1 th - 8, Kines  |



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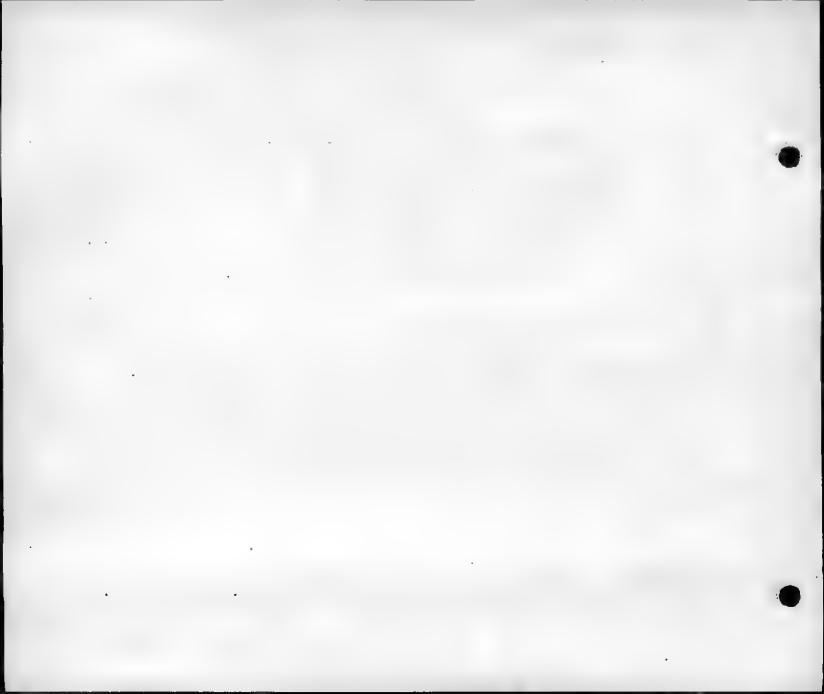
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VS A15 (4) 15M 9/III

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS --- BALTIMORE 1. MARYLAND 7616 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before a. COUNTY o STATE 6 COUNTY Anne Arundel MARYLAND Anne Arundel b. CITY OR TOWN (If outside carparate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 18 days RURAL - Edgewate r annapolis d. NAME OF HOSPITAL (If not in haspital, give street address) W. STREET ADDRESS OR INSTITUTION ON A FARM? Rt-2. Box-213C. YES NO X Anne Arundel General Hospital NAME OF Middle 4. DATE Month Year DECEASED DEATH (Type or print) Leonard WEAVER July 1960 9. AGE (In years last birthday) JE UNDER TYEAR F UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED TO NEVER MARRIED B DATE OF BIRTH Months hite WIDOWED [ Male 12 CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINE) U.S. Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME attending physicial of the control o physicie 17 INFORMANT ARMED FORCES? 18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART : DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o) DUE TO d infection x empyrone Canditians, if any, which gave rise to immediate **DUE TO** cause (a), stating the underlying cause last DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOP YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury is Part I or Part It of item 18.) 20c. TIME OF INJURY 20e PLACE OF INJURY (Hame, farm, | 20f. (City or town) 20d INJURY OCCURRED (County) (State) factory, street, affice bldg., etc Hour a. m. While Not while at wark at wark 21 I certify that (1) (this haspital) attended the deceased from July 7, 19 60 ta July 2], 19 60, that (1) (west last saw the deceased alive on July 21. 19 60 and that death occurred at M, from the causes and an the date stated above DIRECTOR: 22g S GNATURE ATTENDING PHYS. MED DIRECTOR STAFF PHYS 22c PHISICIAN 22d. ADDRESS Barber C. Palmer O FUNERAL Franklin St., Annavolis, 250. REC'D BY REGISTRAL



07648

Reg. Dist. No.

| - | 1. PLACE OF DEATH a. COUNTY   |                             |  | coased lived. If Institution, Reside | ence before admission)               |  |  |  |  |  |
|---|---|-----------------------------|--|--------------------------------------|--------------------------------------|--|--|--|--|--|
| ı | Anne Arundel  | MARYLAND                    | a. State                               | Sprients                             |                                      |  |  |  |  |  |
| ı | CITY OR TOWN (If outside corporate limits, write RURAL and give neares) fown)                                   | c. LENGTH OF STAY IN 16     | Same                                   |                                      |                                      |  |  |  |  |  |
| Į | Pasadena  | 3 years                     |  |                                      |                                      |  |  |  |  |  |
|   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hose  | sital, give street address) | d. STREET ADDRESS                      |                                      | e. IS RESIDENCE<br>ON A FARM?        |  |  |  |  |  |
|   | Pox 3558 West Shorte Rd. Gr   | een Haven                   | Same                                   |                                      | YES NO                               |  |  |  |  |  |
|   | 3. NAME OF First DECEASED   | Middle                      | Lost 4. DAT                            | E Month                              | Day Year                             |  |  |  |  |  |
|   | (Type or print) Charles Henry Wei   | m July 5th.                 | 19 60                                  |                                      |                                      |  |  |  |  |  |
| 1 | 5. SEX 6. COLOR OR RACE 7. MARRIE   | D NEVER MARRIED   B.        | DATE OF BIRTH                          | 9. AGE (In years   IFUNDER           |                                      |  |  |  |  |  |
|   | M MIDOMED   |                             | 1/13/96                                | 7 4 yrs.                             | Days Hours Min,                      |  |  |  |  |  |
|   | 10a, USUAL OCCUPATION (Give kind of work dane 10b, Ki<br>during most of working life, even if retired)          | IND OF BUSINESS OR INDUSTR  | 11. BIRTHPLACE (State or foreign       | n country) 12. CITI                  | ZEN OF WHAT COUNTRY                  |  |  |  |  |  |
| X |   | P.R.R.                      | Germany, Eur                           | ops. U                               | ISA                                  |  |  |  |  |  |
| 4 | 13. FATHER'S NAME   |                             | 14. MOTHER'S MAIDEN NAME               |                                      |                                      |  |  |  |  |  |
| 1 | ?   |                             | Theresa Weider                         | hoft                                 |                                      |  |  |  |  |  |
| ı | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 5   | SOCIAL SECURITY NO. 17. IN  | FORMANT                                | Address                              |                                      |  |  |  |  |  |
|   |   | 7-07-23°6 M                 | rs.Edna Weidenho                       | oft (wife)                           |                                      |  |  |  |  |  |
| Ī | 18. CAUSE OF DEATH [Enter only one cause per line f   | or (a), (b), and (c). ]     |  |                                      | INTERVAL BETWEEN                     |  |  |  |  |  |
| 1 | PART I. DEATH WAS CAUSED BY: COT  | onary Occlusio              | n                                      |                                      | Sudden                               |  |  |  |  |  |
| 1 | DUE TO  |                             |  |                                      |                                      |  |  |  |  |  |
| ١ | Canditions, if any, which) (b)  |                             |  |                                      |                                      |  |  |  |  |  |
| 1 | gave rise to immediate cause  |                             |  |                                      |                                      |  |  |  |  |  |
|   | (a), stating the underlying DUE TO  |                             |  |                                      |                                      |  |  |  |  |  |
| ı |   | NTRIBUTING TO DEATH BUT NO  | OT RELATED TO THE TERMINALDIS          | EASE CONDITION GIVEN IN PAR          | T 1(a) 19. WAS AUTOPSY               |  |  |  |  |  |
| ı | ATK   |                             |  |                                      | YES NO PA                            |  |  |  |  |  |
| - | PART II. OTHER SIGNIFICANT CONDITIONS CO  20a. EXTERNAL CAUSE WAS PRIMARY [] or CONTRIBUTING [] CAUSE OF DEATH. | HOW INJURY OCCURRED. (Em    | iter nature of injury in Port 1 or Por | t II of item 18.)                    | 1                                    |  |  |  |  |  |
|   | PRIMARY O or CONTRIBUTING CAUSE OF DEATH.   |                             |  |                                      |                                      |  |  |  |  |  |
| 1 | 3 20c. TIME OF INJURY Month, Day, Year 20d. II  | NJURY OCCURRED   20e. PLAC  | E OF INJURY (Home, form, 20f. (        | City or town) (Cou                   | inty) (State)                        |  |  |  |  |  |
| ı | 20c. TIME OF INJURY Month, Day, Year 20d. R While at wor  | Nat while foctor            | ry, street, office bldg., etc.)        |                                      |                                      |  |  |  |  |  |
| 1 | 21. I certify that I took charge of the re  |                             | re, held an Autonsy                    | Inspection Ty, Inquir                | y 15th and find tha                  |  |  |  |  |  |
| ı | death resulted from: Natural causes   | _                           | ide [], Homicide [],                   | Undetermined cause                   | / <u>&amp; &amp;</u> dila filia fila |  |  |  |  |  |
| . | 1 - 5   | , , , , , , ,               | Tomicide [],                           | Cildeterisinies casse                |                                      |  |  |  |  |  |
|   | ACTUAL GUSLAND At-  | where Il                    | CHIEF MEDICAL EXAMINER                 | П                                    | DATE SIGNED                          |  |  |  |  |  |
| 1 | SIGNATURE   |                             | M.D. ASSISTANT MEDICAL EXAM            |                                      |                                      |  |  |  |  |  |
| 1 | EXAMINER'S NAME (Type) Chief are II Flowborn  | 1 1/2                       | DEPUTY MEDICAL EXAMINE                 |                                      |                                      |  |  |  |  |  |
| 1 |   | 22c. NAME OF CEMETERY OR C  |  | CATION-(City, Jown, or county)       | -(State)                             |  |  |  |  |  |
|   | REMOVAL Specify) 7. 7 - 60  | Te i vuis                   | 11                                     | · leck less · · · ·                  | . ) ] e [                            |  |  |  |  |  |
|   | 23. FUNERAL DIRECTOR'S SIGNATURE  | ADDRESS                     | 24o. REC'D BY REC                      | /                                    | SNATURE                              |  |  |  |  |  |
|   | ( Exully - 1306. 10   | M Clar.                     | DATE JUL 8                             | '60 arlhur                           | - /-                                 |  |  |  |  |  |
| 1 | 1   |                             | DATE -                                 |                                      |                                      |  |  |  |  |  |

or removol. VS. A15ME(5) 5M 9/55



| d the                           | The same of | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |
|---------------------------------|-------------|--|
| 4 should                        |             | 1. PLACE OF DEATH a. COUNTY A. A. CO. MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) b. COUNTY A. C. O. MARYLAND   |
| Page<br>burial                  | (M)         | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  C. LENGTH OF STAY IN 1b  Sever No. 17046   |
| rector.<br>les.<br>prior to     | nut -       | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  D.O.A. ANNE ARUN del. General Peren Hats.  |
| voer fi<br>egistror             |             | 3. NAME OF DECKASED (Type or print) First Middle Wheat/4 DEATH 7 16 1960   |
| to the fined for ith the r      |             | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH   9. AGE In year lead birthday   15. SEX   WIDOWED   DIVORCED   9-21-35   9. AGE In year lead birthday   Months Days Hours Min.  |
| be reta                         |             | 10a. USUAL OCCUPATION [Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY during most of working life, even if retired)  Low ten May - Academy-House 1/2 Balto. City-Mary Lond U.S. H.   |
| S may<br>oges 1 c               | _           | Vayhr Shiniberry Helen V. Ryder  |
| Give Page 3. Page 1. File Eq    |             | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  NO Bordown Borocom  Who Bentha Borock- Manley Firk-  |
| n 18. Gran P.M3                 |             | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  PRESENTED THE STREET ON THE STR |
| in Iten<br>with for             | ٧           | Conditions, if any, which) (b)   |
| n penci<br>s alang<br>a buria   | 0           | gove rise to immediate couse (a), stating the underlying cause last.  DUE TO (c)   |
| ding" i<br>s Office             |             | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES NO   |
| rd "per<br>raminer"<br>vld be u |             | 200. EXTERNAL CAUSE WAS PRIMARY IS OF CONTRIBUTING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) CAUSE OF DEATH.  20c. EXTERNAL CAUSE WAS PRIMARY IS OF CONTRIBUTING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) CAUSE OF DEATH.   |
| ofical Eyes                     |             | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, farm, 120f. (City ar tawn) (County) (Stole)  Hour Ann. 7-16 1960 at work at work in the global will be seen at work at the global will be seen.   |
| writing<br>hief Me<br>OR: Pag   |             | 21. I certify that I taok charge of the remains described above, held an Autopsy, Inspection, Inquiry, and find the death resulted from. Natural causes Accident Suicide, Hamicide, Undetermined cause   |
| tificate,<br>a the C<br>DIRECT  |             | ACTUAL SIGNATURE SIGNATURE M.D. CHIEF MEDICAL EXAMINER   |
| arded t                         | BADIII      | EXAMINER'S F. LINBAR of DEPUTY MEDICAL EXAMINER 7.16.60.   |
| forwarde<br>TO FUNER            | 5           | 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOGATION (City, town, or county) (State)   |
| 5. A15ME(5<br>5M 9/55           | )           | 23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS  DATEUL 21 '60  CITCLING S. HUMAN   |

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



VR A15 (4) 15M 9/59

| N  | IA | RY  | LA   | ND   | ST   | AT  | Έl | DEI | PA  | RT | N   | \E |
|----|----|-----|------|------|------|-----|----|-----|-----|----|-----|----|
| QN | OF | STA | TIST | ICAL | RESI | EAR | CH | AND | RE  | CQ | RD  | 5  |
|    |    |     |      | CEI  | DTI  | Eli | C  | TI  | E 1 |    | = 1 | n  |

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ENT OF HEALTH

— BALTIMORE 1, MARYLAND

EATH DIVIS

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|   |  |  |  |                                   |                        |   | -                            |                  |  |                    | -14 #                 | 17:41         |                |  |
|---|--|--|--|-----------------------------------|------------------------|---|------------------------------|------------------|--|--------------------|-----------------------|---------------|----------------|--|
| ) | o. COUNTY  | randel   |  | MARYL                             | AND 2.                 | USUAL RES   | and                          | here deceased    | l lived. If institut<br>b. COUNTY            |                    | ce before             | odm ssic      |                |  |
|   | b CITY OR TOWN (if out: RURAL and give nearest Breeklyn Pa                               | tawn)  | ts, write  | c LENGTH OF STAY IN               | N 16                   | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)  Breeklyn Park |                              |                  |  |                    |                       |               |                |  |
|   | d. NAME OF HOSPITAL (I<br>OR INSTITUTION<br>101 14 th                                    | f nat in haspital, g<br>. Ave.   | ive street o   | ddress)                           |                        | d. STREET ADDRESS  101 14th Ave.  |                              |                  |  |                    | IS RESID ON A F.  YES |               |                |  |
|   | 3. NAME OF<br>DECEASED<br>(Type or print)  |  | Le   | as i                              | 4. DATE<br>OF<br>DEATH | Mo<br>Jul∀  | Month I                      |                  |  | 9 60               |                       |               |                |  |
|   |  | olor or race   | 7 MARRI<br>WIDOWEI   | DIVORCED                          |                        | eb. 4   | <sup>тн</sup><br>. 1903      |                  | 9. AGE ( n years<br>last birthday)<br>57 yrs | IF UNDER<br>Months | Days                  | Hours         | Min.           |  |
|   | 10a USUAL OCCUPATION (C<br>during most of working I<br>Houseville                        | Sive kind of work of<br>ife, even if retired   | fane 10b, 1  | KIND OF BUSINESS OR               | INDUSTRY               |   | LACE (State                  | _                | ountry)                                      |                    | T. S                  | WHATCO        | UNTRY?         |  |
| _ | 13 FATHER'S NAME George T  | . Stinche  | cemb   |                                   | 11-                    | 4. MOTHER   | S MAIDEN I                   | Parris           | sh   |                    |                       |               |                |  |
| , | To WAS DECEASED EVER IN [If yes.   | U S ARMED FOR<br>give wor or dates of si   | statca)  | 3-09-6091                         | Mr.                    |   | . W111                       | iar              | Same   | iress              |                       |               |                |  |
|   | Conditions, if any, gave rise to imme couse (a), stating the ying cause last.            | VAS CAUSED BY: LEDIATE CAUSE (G  DUE TO  Which diote DUE TO  (G  IGNIFICANT CON  PLUMA  POPERTYING []  AUSE OF DEATH | D TIONS CO   | ONTRIBUTING TO DEAT               | TH BUT NO              | T RELATED T   | O THE TERM                   |                  | E CONDITION GO                               | VEN IN PAR         | T 1(a) 19             | WAS AI PERFOR | LTOPSY<br>MED? |  |
|   | 20c TIME OF INJURY M<br>Haur a.m<br>p.m.   | lanth, Day, Yes  | While  | JURY OCCURRED 2 Nat while at wark | Oe. PLACE<br>factory   | OF INJURY<br>, street, affi   | (Hame, farm<br>ce bldg., etc | n, 20f. (City    | or tawn)                                     | ((                 | Caunty)               |               | (State)        |  |
|   | 21. I certify that (1) saw the deceased 220. SIGNATURE  22c. PHYSICIAN'S NAME (Type) Me: | alive an.  | attender of the state of the st | 1960, and t                       |                        | ATTENDIP<br>PHYS<br>22d. ADDI   | NG 🍒 🛔                       | ED.<br>IRECTOR [ | the causes of                                | nd an the          |                       | y 20          |                |  |
|   | 23a. BURIAL, CREMATION, REMOVAL (Specify)  Burial  24. FUNERAL DIRECTOR'S SIG            | July 21  |  | 23c NAME OF CEMET                 | ery or cr<br>Cemet     | REMATORY  |                              | 23d LOCAT        | ION (City, tawn,                             |                    | SNATHD                | (State)       |                |  |
| 1 | They I   | /  | 1001   | Hechie Hgw                        | y. Ba                  | lte 25  |                              |                  |  | thun I,            |                       |               |                |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

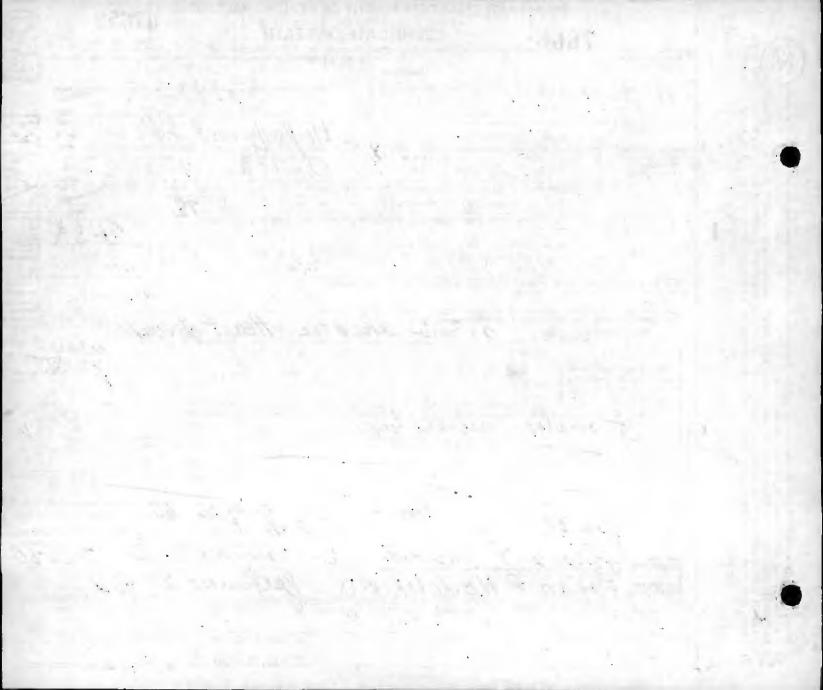
Reg. Dist. No. 07651

| 1.        | PLACE OF DEATH  |  |            |                          | O STATE                           |                               | Where decease  | ed lived. If institu |            | ience be                                | fore odm                                 | ission) •         |
|-----------|---|--|------------|--------------------------|-----------------------------------|-------------------------------|----------------|----------------------|------------|---|--|-------------------|
| <u> -</u> |   | <u>Arundel</u>                                     |            | MARYLAN                  | 2                                 | San                           |                | Sar                  | no         |   |  |                   |
| '         | o. CITY OR TOWN (IF a<br>and give necrost town)   | whide corporate limits, with                       | FRURAL     | c. LENGTH OF STAY IN 1   | c. CITY                           | OR TOWN (II                   | f oviside cor  | porote fimits, write | RURAL on   | d give r                                | eorest fo                                | wn)               |
|           | P.O.Glen 1  |  |            | life                     | A                                 | Same                          |                |                      |            |   | 1  |                   |
|           | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  Lol. Greeway Id. Lalrley Park |  |            |                          | d. STREET ADDRESS                 |                               |                |                      |            | o. IS RESIDENCE<br>ON A FARM?<br>YES NO |  |                   |
| 3         | NAME OF   | Fire   |            | Middle                   |                                   | ant .                         | 4. DATE        | Mont                 |            | D                                       |  |                   |
| 1         | DECEASED<br>(Type or print)   | Terry Lee  |            |                          | •                                 | GRII                          | DEATH          | July                 |            | 196                                     |  | fear<br>9         |
| 5. !      | SEX   | 6. COLOR OR RACE                                   | 7. MARR    | IED 🔲 NEVER MARRIED 🔯    | B. DATE OF BIR                    | TH                            | -              | 9. AGE (In years     | IF UNDER   | TYEAR                                   | IF UND                                   | ER 24 HRS         |
|           | M   | W  | WIDOWI     | ED DIVORCED              | 8/18/                             | <sup>'58</sup>                |                | lost berthday) YES.  | Months     | Days                                    | Hours                                    | Min.              |
| 100       | . USUAL OCCUPATION<br>furing most of working  | (Give kind of work the even if retired)  NONO      | done 10b.  | KIND OF BUSINESS OR INDU | 1                                 | PLACE (Stote<br>timore        | -              | country)             | 1          | usa                                     | F WHAT                                   | COUNTRY?          |
| 13.       | FATHER'S NAME   |  |            |                          | 14. MOTHER                        | 'S MAIDEN N                   | NAME           |                      | ,          |   |  |                   |
|           | John Wi   | indeshein  |            |                          | Dais                              | y Lil                         | ley            |                      |            |   |  |                   |
| 15.       | WAS DECEASED EVEN   | R IN U. S. ARMED FO                                |            | SOCIAL SECURITY NO. 17.  | INFORMANT                         | -                             |                | Address              |            |   |  |                   |
|           |   | No   |            | None                     | Mr and                            | Mrs. J                        | J.Wind         | eshein (             | paren      | ts.)                                    |  |                   |
|           | PART I. DEATH   | WAS CAUSED BY: MMEDIATE CAUSE (o) DUE TO which (b) | 10         | ofer (0), (b), ond (c).] | infecti                           | on                            |                |                      |            |   | RVAL BETW<br>EL <sub>L</sub> AND DE<br>E |                   |
| FICATION  | (o), stoting the uncouse lost.  | derlying DUE TO                                    |            | ONTRIBUTING TO DEATH BUT | NOT RELATED 1                     | O THE TERMI                   | INAL DISEAS    | E CONDITION GIV      | VEN IN PAI |   |  | AUTOPSY<br>PRMED? |
| CERT      | 20g. EXTERNAL CAUS<br>PRIMARY () or CONT<br>CAUSE OF DEATH.   | E WAS<br>TRIBUTING []                              | b. DESCRIE | BE HOW INJURY OCCURRED.  | (Enter nature of                  | injury in Par                 | t I or Port II | of item 18.}         |            |   |  |                   |
| MEDICAL   | 20c. TIME OF INJURY<br>Hour o. m.<br>p. m.  | Month, Day, Yea                                    | Whil       |                          | ACE OF INJURY clory, street, offi | (Home, form<br>ce bldg., etc. | n. 20f. (City  | or tawn)             | (Co        | only)                                   |  | (Stote)           |
|           | 21. I certify the   | at I taak charge                                   | af the     | remains described at     | ave, held a                       | n Autops                      | у 🔲 , П        | nspectian 🔝          | Inqui      | гу 🎇                                    | and                                      | find that         |
|           | ACTUAL SIGNATURE  | etase II   | causes [   | Accident [], S<br>herall | M.D.                              | MEDICAL EX                    | XAMINER [      | ndetermined o        | cause [    | ].                                      | DATE :                                   | SIGNED            |
| L         | EXAMINER'S<br>NAME (Type)   | Gustave H  | Fati       | bert to D                |                                   | TANT MEDICAL I                | _              | _                    | /60_       |   |  |                   |
| 220       | BUR AL, CREMATION<br>REMOVAL (Specify)  | 1/2//  | 1960       |                          | R CREMATORY                       |                               | 22d. LOCA      | TION (City, lown,    | nle        |   | (Stat                                    | e)                |
| 23.       | FUNERAL DIRECTOR'S  | SIGNADAJE  | 61         | Lon Burnie               | Md_                               | 24a. REC'I                    | JUL 1          |                      | STRAR'S SI | GNATU                                   | RE<br>Craced                             |                   |

VS. A15ME(5) 5M 9/55

or remayol.





after death. Page

death certificate be executed

the

ATTENDING PHYSICIAN: The law requires that by the haspital or ottending physician.

0

VR A15 (4)

15M 9/59

| CTOR: After this certificate has been signed by the attended to use as the burial-transit permit. Then play Health prior to burial, cremation, or removal, and in a |
|---|
| CTOR: After this certificate has been signed by e detached for use as the burial-transit permit. If Health prior to burial, cremation, or remaval.                  |
| CTOR: After this certificate has been si<br>e detached for use as the burial-transit<br>of Health priar to burial, cremation, or r                                  |
| CTOR: After this certificate has be eletached for use as the burial-to the Health prior to burial, cremation  |
| CTOR: After this certificate e detached for use as the buril Health prior to buriol, cret   |
| CTOR: After this certified detached far use as is Health priar to burion  |
| CTOR: After this<br>e detached far us<br>of Health priar to   |
| CTOR: Affe<br>e detached<br>of Health pri   |
| crox<br>e deto  |
|   |

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY Maryland Anne Arundel MARYLAND Anne Arundel b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town) 16 days Annapolis Glen Burnie d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES NOT Plaza Manor Nursing Home Calvert Street NAME OF First Middle 4. DATE Month Last Yeor Day DECEASED 19 60 July 30. DEATH (Type or print) Ernest Young 6. COLOR OR RACE 7. MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX B. DATE OF BIRTH 9. AGE (In years last birthdoy) Months Doys Hours Male Negro WIDOWED 1 DIVORCED [ 59 yrs 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Store or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) Ilnknown U.S.A. Unknown Annapolis. Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Ella Parker William Parker 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17 INFORMANI SOCIAL SECURITY NO Address Mrs. Alice Brown-A.A.Co. D.P.W. Unitality 1B. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ? yrs. Hypertensive cardio renal vascular disease IMMEDIATE CAUSE (c) DUE TO Candilians, if any, which gave rise to immediate DUE TO couse (o), stating the underlying couse last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO I 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 1B.) 20c. TIME OF INJURY Day. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (State) (County) factory, street, affice bldg., etc.) WEDI o. m While Not while of work at work p. m. 21. I certify that (I) (this haspital) attended the deceased fram July 111. 19 60 that (1) (we) last deceased alive an July SOM the , and that death accurred at A. M., from the causes and an the date stated above. SIGNATURE 22b. DATE SIGNED ,1960 PHYS PHYS. DIRECTOR 22c. PH SICIAN'S 22d. ADDRESS ME (Type 400 N. Carrollton Ave. Balto. 23, Md. Pair. ames M. 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tawn, or county) (State) Burial (Specify) 2-60 Brewer Hill Annapolis. 256, REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 250. REC'D BY REGISTRAR Chilling S. Through 160 DATELUG 3 C.E. Hicker 111 Annabolis. Maryland

Laboral with . . The state of the s , , -----BOUNE TO SHIP TO SAIL